AN EXPLORATION OF SOCIAL POLICY RESPONSES FOR ORPHANS AND VULNERABLE CHILDREN IN BOTSWNA

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PLAGIARISM DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

I have used the Harvard Method of referencing.

Signature: Signed by candidate Date: 24/05/2012

DEDICATION

This minor dissertation is dedicated to my late mother, Mosadinyana Mpoelang Motlogelwa, who taught me through her actions how to be human.

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ABSTRACT

This study explores whether social policy responses for orphans and vulnerable children in Botswana address the needs of this category of children. The objectives of social policies and legislation (such as the Constitution, the Children's Act of 2009, the National Guidelines on the Care of OVC of 2008, and the Botswana National Plan of Action for OVC of 2010-2016) in relation to social protection are analysed, and the availability, accessibility and adequacy of the HIV and AIDS social protection measures for OVC, namely prevention of mother-to-child transmission, antiretroviral therapy, and community home-based care and orphan food baskets, are described.

The study argues that these social policy responses for OVC are inadequate and do not comprehensively meet the needs of OVC. There is an inadequate legal and policy framework, fragmentation of social protection provisions, inadequate minimum eligibility criteria, shortage of human resources, insufficient funding, lack of awareness, and the presence of stigma and discrimination. These present barriers to the availability, accessibility and adequacy of social protection provision to OVC.

The study recommends comprehensive social protection within the broader social policy for OVC, to address some of the problems that have been highlighted. Such a policy needs to be based within a human rights based framework and developmentally or progressively achieved.

LIST OF ABBREVIATIONS

ACHPR	African Commission on Human and People's Rights
ACRWC	African Charter on the Rights of the Child
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
AU	African Union
BAIS	Botswana AIDS Impact Survey
BIPAI	Baylor International Paediatric AIDS Initiative
BFTU	Botswana Federation of Trade Unions
BIDPA	Botswana Institute for Development Policy Analysis
BOTUSA	Botswana-USA Partnership
CHBC	Community Home-Based Care
CKGR	Central Kgalagadi Game Reserve
CCA	Common Country Assessment
CSO	Central Statistics Office
EC	European Commission
GDP	Gross Domestic Product
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
IMF	International Monetary Fund
IWGEA	International Working Group for Indigenous Affairs
MFDP	Ministry of Finance and Development Planning
MLG	Ministry of Local Government
MOH	Ministry of Health
NAC	National AIDS Council
NACA	National AIDS Coordinating Agency
NDP	National Development Plan
NSF	National Strategic Framework on HIV/AIDS
NSPR	National Strategy on Poverty Reduction
NPA	National Plan of Action
NGO	Non-Governmental Organization
OAU	Organization of African Unity

OECD	Organisation for Economic Co-operation and Development
OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother-to-Child Transmission
RHVP	Regional Hunger and Vulnerability Program
SADC	Southern African Development Committee
STPA	Short-Term Plan of Action
TB	Tuberculosis
TPSD	Transitional Plan on Socio-Economic Development
UNICEF	United Nations Children's Fund
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNGA	United Nations General Assembly
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNOHCHR	United Nations Office of High Commissioner for Human Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
WB	World Bank
WHO	World Health Organisation

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CHAPTER ONE
INTRODUCTION

1.0 Introduction

Due to its diamond mining industry Botswana performs well economically, compared with most African countries. At the same time, it is faced with many challenges such as poverty, unemployment, and the HIV and AIDS epidemic, which is the second highest in the world (UNAIDS, 2010; Throupe, 2011). In particular, the HIV and AIDS epidemic has had a devastating impact on children, leaving them vulnerable to being both infected and affected. In 2008, the Ministry of Local Government (MLG) estimated that approximately 16.2% of the country's children were orphans as a result of AIDS, and many more had been made vulnerable by the epidemic (MLG, 2008a). The majority of orphans and vulnerable children (OVC) live in poor rural households, as their caregivers suffer from unemployment, low income and skills, and therefore suffer from poverty. Despite government putting in place social protection measures to address HIV and AIDS, it can be argued that these are not comprehensive. There are still challenges of availability, accessibility and adequacy. This study focuses on exploring whether the social policy measures for OVC are meeting their needs. Firstly, in order to understand the extent of these needs, it is essential to define what it means to be an OVC in Botswana.

Orphanhood is defined at national and international levels. In Botswana, orphans further have both social and policy/legal definitions. Socially, they are defined as abandoned or dumped children whose parents cannot be traced (MLG, 2010). For policy and legal purposes, the Botswana National Plan of Action for Orphans and Vulnerable Children (NPA) of 2010-2016 defines an orphan as a child aged below 18 years who has lost one or two biological or adoptive parents who were married in civil or customary unions (MLG, 2010). This policy/legal definition is one that is used by Botswana to provide an estimate of the prevalence of orphans and the numbers entitled to social assistance provision (MLG, 2008a), and will be used in this study to explore government provision of social assistance to OVC.

Using the Botswana policy/legal definition, 16.2% of the children out of an estimated 779,000 total population of children are orphans (MLG, 2008a). This is higher than the 111,828 or 15.2% reported as OVC in the 2001 census (MLG, 2008a). Those children orphaned because of AIDS are approximated to be 93,000 (UNAIDS, 2010).

The problem of orphanhood is even more dire, considering the country's small population of 2 million (CSO, 2011) that is still grappling with one of the highest HIV prevalence globally, at 17.6 % (Botswana Government and UNAIDS, 2010). The situation is further aggravated when adding vulnerable children to the issue of orphanhood. The policy definition of a vulnerable child is a child who is below the age of 18 years and meets all or some of the following criteria: lives in an abusive environment; lives in a poverty-stricken family and cannot access basic services; lives in a child-headed household; lives with a sick parent or guardian; is infected with HIV; and lives outside family care (MLG, 2008b). According to MLG (2008a), these above criteria of vulnerable children poses a challenge to establishing the number of vulnerable children in the country, due to difficulties in measuring in a uniform manner some of the criteria such as, a child living in an abusive environment.

1.1 Statement of the Problem

The growing number of OVC in Botswana has severely impacted the ability of families and communities to provide for the poor and needy, due to lack of resources. In essence, the HIV and AIDS epidemic has claimed the lives of between 5000 and 11 000 adults per year since the first case was detected in 1985 (Stover et al., 2008), leaving children both infected and affected. The effects of the epidemic on children have been further exacerbated by the already existing problems of poverty and unemployment. Children have largely been left in the care of the women who are unemployed and thus are unable to properly care for OVC (MLG, 2008a; CSO & NACA, 2009).

This is in contrast to the traditional Botswana society where the needy in the community were taken care of by the informal social protection system. As far as this informal assistance was concerned, the nuclear family was the first point of providing any help needed, and if unable to assist the extended family assumed the responsibility. In the event that the immediate and extended family was unable to provide, the community was expected to assist. This approach to social provision by the family and community is known as the residual social policy approach. It is argued by Ntseane and Solo (2007) that due to this informal assistance the problem of orphans in the past was not as evident as family and the community provided for these children. MLG (2002) stated that the extended family catered for all kinds of needs, which included "material, social or emotional". Presently, the scale of the problem is too large for families and communities to cope and the increasing number of OVC has, amongst other factors, resulted in the breaking down of traditional informal social protection systems (Ntseane and Solo, 2007). As argued by Ntseane and Solo (2007), with many households

unable to cope with the OVC crisis, government was prompted to respond. The Short-Term Plan on Care of OVC (STPA) of 1999 was the first policy to respond to the situation of orphans in Botswana (MLG, 2010). According to Feranil et al., (2010), the STPA was the first direct response to the social changes that were taking place in the country as a result of the devastating impact of the epidemic.

The government later developed the 2008 National Guidelines for Care of OVC (MLG, 2008b) and the NPA for OVC of 2010-2016 (MLG, 2010). The NPA for OVC noted the shortcomings of the STPA, stating that "structural poverty at household level undermines the capacity of the family to care for orphans and vulnerable children and this has further compounded by rapid demographic changes that have further eroded the family capacities to provide, protect, care and support orphans and vulnerable children" (MLG, 2010:2). Furthermore, "the structures, systems and procedures for providing social services have not kept to pace with the increasing demand for orphans and vulnerable children" (MLG, 2010:2). This applied in particular to the non-governmental, faith-based and community organizations that have been instrumental in social provision for OVC but had limited coverage due to lack of resources (MLG, 2008a). Therefore, the government has the responsibility to ensure that there is adequate support in meeting the unmet needs of OVC to avoid a disintegrated society.

1.2 Rationale for the Study

The magnitude and persistence of the problems outlined above necessitate a study to explore the government's social policy response for OVC. This study presents an intersection of interest at practical, academic and personal levels. At a practical level, the study addresses the daily reality faced by OVC in Botswana. The persistence of the deprivation of adequate food, nutrition, education, and health, and the incidences of HIV and high mortality rates caused by AIDS and other preventable diseases, when government has the capacity to deal with these issues, prompt an investigation into the issues. At an academic level, there is a policy and social need to conduct the study and make suggestions for reform where gaps still exist. And finally, at a personal level, being from Botswana and having interacted with OVC, I am gravely concerned about these children.

Evidence suggests that Botswana needs a comprehensive social protection policy. In 2007, an empirical study (the *Review of Social Safety Nets in Botswana*) was undertaken by the Botswana Institute for Development Policy Analysis (BIDPA) under the direction of the Ministry of Finance and Development Planning (MFDP) (Seleka et al., 2007). The study

focused mainly on the issues relating to the administration, targeting and sustainability of social safety net programs (Seleka et al., 2007). According to Seleka and colleagues, the study noted the problem of fragmented social welfare programs and suggested the development of an integrated and inclusive framework. Although the orphan program was also included in the study, the analysis did not focus on whether the social protection measures are meeting the needs of OVC.

In addition, Kaseke, in the foreword to Ntseane and Solo's book *Social Security and Social Protection in Botswana*, pointed out the limited studies undertaken on social protection in the Southern African Development Community (SADC) region, including Botswana (Ntseane and Solo, 2007). Similar to Seleka et al., (2007), Ntseane and Solo emphasized the need for a comprehensive social protection policy, but examined the issue from the integration of formal and informal social protection (Ntseane and Solo, 2007).

Taylor (2008:23) argues that at policy and conceptual levels, recent shifts in thinking about social protection highlight its role as a "comprehensive developmental policy that is seen as a necessary component of growth and human development". This suggests that both economic and social policies need to be in harmony so that children are provided with sufficient nutrition to grow up with the mental and physical capacity to enable learning when provided with opportunities to go to school. With access to schooling, a child becomes an investment and future resource for the country and contributes to growth. Thus, social protection is now being understood as not limited to a minimalist vision of being "residual welfare or safety net" but rather as embedded in the normative approach that ensures inclusion of the poor and marginalized in the development process by guaranteeing rights to everyone (Taylor, 2008:7). This suggests that social protection is no longer viewed as secondary to growth but as an important element of growth and necessary for the well-being of people, while simultaneously protecting and promoting human rights, particularly of the poor and marginalized such as OVC, the focus of this study.

This study adds value to the debate, especially in a country that has largely (although not entirely), pursued a neoliberal-residual approach to social policy. This approach has created gaps in the social protection system, especially in social provision to the OVC. It is envisioned that the study will shed light on areas that need reform.

1.3 Significance of the Research

The NPA of 2010-2016 has noted that there is need for "human rights-based approaches to the provision of child-sensitive social protection services to orphans and vulnerable children" (MLG, 2010:4). According to UNICEF (2010) child-sensitive social protection means that special provision needs to reach children who are particularly vulnerable and excluded. This suggests that the needs of the 16.2% of Botswana's children who are OVC – who are at risk of contracting the HIV virus, those who are already infected, and those who live in households that are poverty-stricken and deprived of basic necessities such as health care, education, adequate food and nutrition – have to be met (Arnab and Serumaga-Zake, 2006; MLG, 2008a). Taylor (2008) pointed out that these above measures are critical for social protection and are fundamental for human development and economic growth.

Since it has been established that the informal social protection system is inadequate, the question is: who will provide for the OVC? MLG (2008a) argues that non-governmental, community based and faith-based organizations have limited resources to cater for OVC. In light of this, the onus falls on the government of Botswana, which has committed in its various policies to ensuring provision for OVC (MLG, 2010). By exploring social policy responses by the government, this research will provide strategic options for reform. It will also act as a resource for government and other organizations engaged in the promotion of well-being of OVC.

1.4 Research Questions

The central research question of this study is: Are the social policy measures for orphans and vulnerable children in Botswana addressing the needs of these children? The sub-questions include:

- What are the social protection objectives of the legal and policy frameworks (Constitution, Children's Act of 2009, 2008 National Guidelines on the Care of OVC and the National Plan of Action for OVC of 2010-2016)?
- What social protection measures relating to HIV and AIDS have been made available to OVC in Botswana?
- Are OVC able to access these HIV and AIDS social protection measures?
- Are these HIV and AIDS social protection measures adequately meeting the needs of OVC?

1.5 Research Objectives

This study's broad objective is to explore whether the social policy measures for OVC in Botswana are meeting their needs by analyzing the social protection objectives in the legislation and policies and the availability, accessibility and adequacy of HIV and AIDS social protection measures in order to suggest strategic options for reform as recommendations. The **specific objectives** are to:

- Assess the adequacy of legislation and policy in relation to social protection for OVC.
- Identify and discuss the availability of HIV and AIDS social protection measures for OVC.
- Examine the accessibility of HIV and AIDS social protection measures by OVC.
- Determine the adequacy of the HIV and AIDS social protection measures for OVC.
- Propose strategic options for reform as recommendations

1.6 Clarification of Concepts

Conceptual clarity is imperative, particularly for any engagement in a discussion relating to social protection. This section defines some of the key concepts that will be used throughout this study.

In the Collins Concise dictionary, "availability" means "obtainable or capable of being made of use", with "accessibility", referring to "easy to approach, enter or use", and "adequacy" is the "ability to fulfill a need" (Sinclair, 2000). According to UNGA cited in Hakijamii Trust (2007), for social protection to be available, it needs to be established under the law; be fiscally viable, sustainable and responsive to conditions; provide adequate benefits in amount and duration of payment; be accessible so as to extend social security provision to those lacking coverage, economically affordable and, physically accessible to beneficiaries.

To this end, in this study, the types, awareness level and presence (at the geographical location of OVC) of social protection measures are indicators of availability of these measures. Eligibility criteria, delivery points and existing institutional and financial barriers are indicators of the accessibility of these social protection measures. Extent of coverage and ability to meet the needs of OVC are indicators for adequacy.

Child

The legal definition of a child is any person that is below the age of 18 years (Botswana Government, 2009).

Orphan

A child below 18 years who has lost one (single) or both parents (married couples). These parents are either biological or adoptive. Married couples include those married under civil law or traditional marriages. This can include social orphans who are children that are abandoned, dumped and whose parents cannot be traced (MLG, 2010).

Vulnerable Child

A child below the age of 18 years who meets any of the following criteria: lives in an abusive environment; lives in a poverty-stricken family and is not able to access basic services; lives in a child-headed household; lives with a sick parent(s) or guardian; is infected with HIV; and lives outside family care (MLG, 2010). In this study it also includes a child that is at risk of contracting HIV.

Social Policy

Defining social policy is complex and multi-dimensional as it is influenced by many factors, some of which are contextual and others in which value and ethical considerations take precedence (Gil, 1992). Its method of enquiry is multi-disciplinary, drawing from fields such as sociology, economics, history and philosophy (Mishra 1977). The multi-faceted definition of social policy is illustrated by Freeman and Sherwood cited in Gil (1992:4), who describe it in four layers: "as a philosophical concept, a product, a process and framework of action". These four elements of social policy are referred to as follows:

- As a philosophical concept is a principle whereby the members of large organizations and political entities collectively seek enduring solutions to the problems that affect them;
- As a product, social policy consists of the conclusions reached by persons concerned with the betterment of community conditions and social life, and with the amelioration of deviance and social disorganization. An example of this would be a White Paper;
- As a process, existing social policies are never fully developed but are continually modified in the face of changing conditions and values;
- As a framework of action social policy is both a product and a process, assuming the availability of well-delineated policy which is to be implemented within the context of

potential changes in the values, structure, and conditions of the groups affected (Gil: 1992:4).

For the purpose of this study, Freeman and Sherwood's definition as cited by Gil, (1992) will be used as it encompasses all the relevant policies affecting OVC which are to be analyzed.

Social Protection

There is no consensus to the definition of social protection and it is explained differently by development agencies, academia and states (Holzmann and Jorgensen, 2000; Gross, 2007; Brunori and O'Reilly, 2010; Oduro, 2010). Sabates-Wheeler and Devereux (2004:9), for example, define it as "all public and private initiatives that provide income or consumption transfers to the poor protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalized, with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups". This study will use Taylor's definition, which states that "social protection sits at one end of the category of social policies and interventions that protects individuals, families and communities against economic crises and other forms of vulnerabilities as well as promotes growth and human development" (Taylor, 2008:39). In its comprehensive form, social protection can consist of a "range of public (government-funded) measures that give support to all citizens and helps individuals, households and communities to better manage risks and participate effectively in all spheres of life" as well as health, education and housing (Taylor, 2008:43).

Social Assistance

Social assistance refers to government funded or publicly provided basic protection in cash or kind benefits to relieve poverty, especially to those experiencing vulnerabilities such as age, disability and disasters (Taylor, 2008). For the purpose of this study, Taylor's definition of social assistance will be used.

Using Taylor's approach, Figure 1 below illustrates the relationship between social policy, social protection, and social assistance as set of sub-sets of comprehensive role of social protection within the broad social policy framework which becomes narrow towards social assistance (Taylor, 2008).

Figure 1: Taylor's approach on the relationship between social policy, social protection and social assistance

Taylor's conceptual framework on social protection for Africa (Taylor 2008) has been adopted and modified to make it relevant to the needs of this study, particularly to guide the literature review and analysis. This framework has been chosen as it applies to the African context and to historical and structural deprivations. The framework is also appropriate in the context of high poverty, unemployment, and HIV prevalence. The Taylor framework (Taylor, 2008) enables looking at the background of social protection, the prevailing socio-economic and demographic conditions of the country; clarification on its nature; the values, principles, functions that underpin social protection programs, and the challenges that exist. It also provides strategic options for reform. The modifications are illustrated in the next section, which also presents an overview of Botswana's socio-economic, demographic context and background to social protection.

1.7 Socio-Economic and Demographic Context of Botswana

The social policy responses for OVC in Botswana are located within the country's socio-economic and demographic trends that include poverty, unemployment, and HIV and AIDS. These trends have impacted on the well being of children in many ways and they will be discussed in Chapter 2. Table 1 below shows some of the country's key trends social-economic and demographic over the last two decades.

Table 1: Socio-Economic and Demographic Trends (National)

Indicator	Socio-Economic and Demographic Trends		
National Population	1,588,745 (1998)	1,680,863 (2001)	2,038,228 (2011)
Annual Growth pa %	4.6 (1971)	3.5(2001)	1,9 (2011)
Life Expectancy years	62 (1998)	56(2001)	55.6 (2009)
Literacy Rate %	68 (1994)	81 (2003)	84.8 (2010)
National HIV Prevalence %	-	17.1% (2004)	17.6 (2008)
HIV Prevalence (15-49) %	-	35.4% (2002)	24.6 (2010)
Maternal Mortality (per 100 000)	326 (1990)	193 (2007)	189 (2010)
GDP Per Capita $	7655.533(1998)	10,860.83(2003)	15,179.74(2010)
Human Development Index (Rank)	122 (2000)	125 (2004)	98 (2010)
Human Development Index	0.576 (1990)	0.593(2005)	0.633 (2010)
Poverty Below National Poverty Line	47 (1993)	37.4% (2001)	30.6 (2011)
Unemployment Rate %	20 .8% (1998)	17.6% (2005)	26.2 (2010)
Access to Safe Drinking Water %	-	87(2001)	97 (2008)
Access to Improved Sanitation %	-	38 (1990)	60 (2011)

Sources: CSO (2011, 2010, 2009a, b and 2008a); Botswana Government and UNDP (2004, 2010); Botswana Government and UNAIDS (2008, 2010); CSO and NACA (2005, 2009); UNDP (2010); WB (2010) and WHO (2011).
Note: - Data not available

1.7.1 Demographic Context

Botswana is relatively small compared to other countries in Africa, with an estimated population of 2 million (CSO, 2011). The preliminary results of the 2011 population census depict a growth rate of a "diminishing population" (CSO, 2011:1). This is a result of a downward trend in the annual growth rate between 1971 (4.6%), 2001 (3.5%) and the 2011 rate of 1.9% (CSO, 2011). A falling population means that there will be limited labor to contribute to the economy to meet the needs of future generations. It is estimated by CSO (2009a) that the majority of the population resides in rural areas (48%) than in urban villages (33.2%) and cities (22%). The current settlement pattern is different from that at independence, when 94% of the population was mainly rural (CSO, 2009a). Such a shift in settlement patterns has been attributed to migration from rural to urban areas in search of employment, especially by youth who face limited opportunities in rural areas (MFDP, 2010). Children under 14 years also reside mostly in rural areas due to many households being headed by women (CSO and NACA, 2009).

The low growth is attributed to low fertility, which has declined from 4.3(1996) to 2.9 (2007) per children per woman (MFDP, 2010). Along with low fertility rate there has been a decline in life expectancy. The life expectancy was much higher in 1998, when it was 62 years, than in 2009 at 56 years (Botswana Government and UNDP, 2010). Such a drop in life expectancy

is attributed to HIV and AIDS, which has impacted on individuals, families, communities and society as a whole. The impact has been felt increasingly by poor households and even more so by children (MLG, 2008a).

1.7.2 Social and Economic Context

1.7.2.1 Poverty and Unemployment

Poverty in Botswana is better understood in relation to age, gender and spatial distribution. But firstly, it is important to appreciate what it means to be poor. Various terms of poverty have been advanced, demonstrating the complexities associated with its definition. The focus on insufficient income or consumption deprivation and the means to satisfy a socially acceptable minimum standard of living are some of the explanations that have been provided (Singh, 2005). Low income is explained as an inability to have money to pay for basic necessities such as food, education and health care for oneself or ones family. According to Taylor, (2002:15) poverty is the "inability of individuals, households or communities to command sufficient resources to satisfy a socially acceptable minimum standard of living". Sen (2010:254) argued that "different people can have different opportunities for converting income and other primary goods into characteristics of good living and in the kind of freedom valued in human life". This implies that people attach different meaning to different things. For example, one household's need may be in the form of income in order to satisfy lack of food for the family, whilst another household would need land to meet a similar need. Sen, therefore, does not necessarily abandon the idea of income as being useful in defining poverty.

Sen (1999) argued for a much broader notion of poverty that emphasizes capability deprivations. According to Sen (1999), human deprivations also extend to unemployment, ill health, lack of education, exposure to risks, vulnerability, social exclusion, powerlessness and voicelessness. Sen's holistic view on poverty calls for various social policy responses that are able to tackle the multiple dimensions of poverty. According to Patel (2005) the normative approach is able to address these abovementioned problems by promoting inclusion, participation, equal access to services and benefits including opportunities to enable human development. In line with this, the NSPR also partly embraced a capability approach (MFDP, 2003). Poverty, thus, is viewed as having three dimensions that include "income, human capabilities and participation" (MFDP, 2003:4). Income poverty refers to earnings below the average (P4, 120/US$685) (CSO, 2010) monthly income in Botswana), with human capabilities suggested to be education, training, health, nutrition, and infrastructure (MLG,

2003:4). Lastly, participation refers to "promoting popular participation both through continuous policy dialogue and consultations with communities and other stakeholders, and through adoption of decentralised district processes that emphasise bottom-up planning" (MFDP, 2003 4-5).

In Botswana, 30.6% of the population is considered poor, with the majority of this group being rural woman (MFDP, 2011). This suggests that children who reside in rural areas are at risk of being poor. The national unemployment has increased from 17.5% in 2005 and currently at 26.2% (Botswana Government and UNDP, 2010). The limited job opportunities can leave people poor, and even more so in Botswana where people no longer rely on subsistence farming to meet their basic needs, such as food (MFDP, 2009). The lack of income puts a strain on households' ability to provide for their children. With the recent announcement by the government to downsize the civil service, unemployment is likely to get higher. The need to reform the public sector came as a recommendation from IMF to improve efficiency (IMF, 2010). This is in line with the neoliberal view of worrying more about monetary costs than the cost of human deprivation.

Evidence shows that the employed population is found mostly in urban areas (65.5%), with only 34.5% of those in rural areas managing to secure jobs (CSO and NACA, 2009). This means that OVC in the rural areas are already disadvantaged, as their caregivers are mostly rural women. Youth and women make up the majority of the unemployed. Youth aged 20-24 account for 34.9% and those aged 15-35 at 69% of the unemployed people (CSO, 2008a). The distribution by gender shows that women bear the highest burden, with 62.5% being unemployed (CSO, 2009a). Some of the reasons for this lack of employment are the decreasing number of job opportunities and increasing labor force with fewer skills and experience required by the labor market (BIDPA, 1997; Siphambe, 2007). Throupe, (2011:17) argues that Botswana's macroeconomic approach has failed to create jobs and sees the country as facing a "disaster" in the next 10 to 20 years if there is no change in strategy. This scenario is likely to affect children, especially those from poorer families, leading to intergenerational poverty, and more so OVC who are already feeling the effects of HIV and AIDS.

1.7.2.2 HIV and AIDS, TB and Malaria

HIV and AIDS have been a major burden for the country, despite the existence of other health deceases such as tuberculosis (TB) and malaria (MFDP, 2010). Botswana is second only to

Swaziland in shouldering the global disease burden, with an estimated HIV prevalence of 17.6% from 17.1% in 2004 (CSO and NACA, 2009; UNAIDS, 2010). The epidemic has had a devastating demographic, social, and economic impact on almost every aspect of the country's society, especially on individuals, families, households, communities and the lives of children in the country. The adults between 15-49 years in their reproductive age group and also considered the main income earning group have the highest infection rates of 24, 6% (CSO and NACA, 2009; Botswana Government and UNAIDS, 2010). The HIV virus infects mostly women (24.4%) compared to men (14.2%) in the above adult age group (CSO and NACA, 2009). This has an effect on OVC, whose caregivers are mostly women. Due to the epidemic, high numbers of adult deaths have ranged from 5000 to 11 000 per year (Stover et al., 2008) and elevated maternal and child mortality (CSO, 2009b; UNICEF, 2011; and WHO, 2011).

Besides HIV and AIDS, malaria and TB have also contributed to increased death in the country (MFDP, 2010). It has been indicated that 2009, TB accounted for 70% of all the HIV and AIDS-related deaths (MFDP, 2010), with 14 878 reported malaria cases (WHO, 2011). The high HIV prevalence that co-exists with the high mortality rates suggests that children whose parents die or are sick at an early age lose parental support (which includes providing for their physical, emotional and material needs), risking their chances of survival.

1.8 Background to Social Protection in Botswana

This section provides a background to social protection in Botswana. In order to understand the social policy response to OVC, there is a need to understand the genesis of the social protection system in Botswana, which is embedded in some of the country's societal and adopted values and principles articulated in various policies. This section therefore emphasizes the underlying values and principles of social protection pre and post independence.

Botswana was amongst the poorest countries in the world at independence in 1966. This was also exacerbated by a prolonged drought. According to Tlou and Campbell (2003), the British colonial administration's provision of basic services such as education, health, water, vocational training was insufficient. As such, the newly independent Botswana was forced to rely on aid from donors to help pay for basic services. According to Kaseke in Midgley and Piachaud (2011), statutory social assistance during the colonial era was based on racial discrimination, with the assumption that Africans did not need it. Mwansa et al., (1998) argue

that social provision in Bechuanaland (colonial Botswana) was meant for colonial expatriates, whereas the rest of society had to rely on communities and extended family.

Mishra (1977) argued that the residual approach had minimal government intervention. This suggests that the colonial social provision was rooted in the residual approach, as public social protection benefits catered only for the colonial administrators (who were the minority) and excluded the majority Batswana population. The majority of Batswana who were poor had to provide for themselves through family and community support, with insufficient support coming from the colonial government. Taylor (1987:40) pointed out that "*go busa dikotlo*" – where parents took the responsibility of caring for their children with the expectation that the children would reciprocate when they will be older – was common. Therefore, the social protection provision to the majority of Batswana was inadequate as a result of the limited government intervention and the exclusion of the majority that were in need.

The limited role of the colonial government in providing social assistance to poor communities was to save costs and to promote self-reliance (Mwansa et al., 1998). According to George and Wilding (1994), market-based ideas see social provision by the government as economically damaging as it takes away individual responsibility. The cost-recovery strategy is within the residual-neoliberal approach of emphasizing efficiency rather than making social provision more equitable and inclusive, especially at a time when the majority of the population was poor. Furthermore, the principle of self-reliance was not appropriate. Government assistance was required to tackle the needs of the poor. For that reason, the pre-independence approach to social policy provision was heavily rooted in the residual-neoliberal approach, which neglected the needs of the majority of the population who were in need but who were nonetheless excluded.

An informal social protection system in Botswana has played a significant role. Before independence in 1966, the values and principles within society that guided such social provision were solidarity and reciprocity to bring *kagisonyo*, or social harmony. It is argued by Ntseane and Solo (2007) that within the principle of solidarity, the members of the nuclear and extended family had a sense of shared duty towards each other. Thus, the immediate and extended family was the immediate social provider to the indigent as a way of bringing unity. According to Taylor (1987), the benefits would include, amongst others, food and shelter. The principles of solidarity, social harmony and reciprocity are values shared by the social democrats to promote altruism (Titmus in George and Wilding, 1994) and reject the rugged

individualism that is prominent within the neoliberal view of opposing government assistance (Gil, 1992). Hence, during the difficult periods, extended families felt a social obligation to care for each other.

Reciprocity referred to the mutual support within the community that was carried out through a *mafisa* system (Taylor, 1987). According to Datta and Murray in (Holm and Molutsi, 1989), the *mafisa* system saw poor households being entitled to use a rich family's cattle for such things as milk, transport, ploughing the land and harvesting, in exchange for taking care of these cattle. The informal social provision continued into independence until other social changes such as HIV and AIDS became too overwhelming for households, particularly those with OVC.

As poverty remained a major concern, social protection found its place on the agenda of government after independence. The Transitional Plan for Social and Economic Development (TPSD) of 1966-1969 guided the first social protection program, known as the Drought Relief Program and was supported by World Food Program (WFP) (Ferguson-Brown, 1996). This Drought Relief Program was to provide relief to deal with the effects of drought that had left many extremely poor and with no access to food (Ferguson-Brown, 1996).

According to Holm and Cohen (1988), the drought crises of the 1980s that altered and disrupted the nature of the rural economy enabled the Drought Relief Program to focus on two social protection measures, notably the supplementary feeding and "food for work". The supplementary feeding included vulnerable children and was aimed at enhancing the nutritional status and health of pregnant and lactating mothers, children under five years, children between 6 and 13 years, TB patients and malnourished persons (Holm and Cohen, 1988). The provision of food for work and later cash for work (also known as *Ipelegeng*, or self-help) labor-based relief program was in exchange for building community infrastructural assets such as roads, dams and schools (Holm and Cohen, 1988). The National Development Plans, Vision 2016, NSPR, and the Revised Rural Development Policy would later articulate social safety nets as social assistance strategy by government to address the needs of the very poor, which includes the elderly, female-headed households, World War II veterans, remote-area dwellers, and the concern of this study, OVC (Seleka et al., 2007).

These overarching development policies are underpinned by the principles and values of democracy, social justice, self reliance and *botho*. These principles were derived from

Botswana's cultural heritage to promote *kagisano*, which means social harmony, and became one of the aims for basic education for children (Presidential Task Force, 1999). The principle of democracy was embraced when the new government took over from the colonial powers. Hence, Abraham Lincoln's vision of a government of the people, by the people, and for the people was echoed as the driving force for democracy (Holm and Molutsi, 1989). The new government wanted to be seen as serving the interest of all its members as opposed to the colonial government, which only served the minority.

Social justice referred to "democratic way of life, the protection of human rights, and the availability of basic needs, and equal access to economic opportunities" (MFDP, 1991:32). Taylor (2008) argues that social protection should be aimed at promoting social justice. Thus social justice required fairly and equitably distributed social measures to benefit those who are most disadvantaged (Rawls, 1971). As a result, Botswana's developmental policies emphasized social assistance for the very poor. However, there is evidence to suggest that social justice has not been achieved. There is still the persistence of poverty that affects OVC and their caregivers (MLG, 2008a). Self reliance is rooted in the idea that government social provision undermines the efficient working of the market and the obligation of the family. This means that people should provide for themselves and not look up to government for support. Therefore the labour intensive program adopted the local name *Ipelegeng*- meaning self-help to instil a sense of self-reliance (Ntseane and Solo, 2007). RHVP (2011) suggests that *Ipelegeng* provides short-term and insufficient work opportunities. This means that beneficiaries of *Ipelegeng* are not able to adequately provide for themselves and their needy children in the long term.

These above principles include the notion of *botho* which is understood as "the state of being courteous and highly disciplined in one's endeavours to achieve one's potential as a human being while encouraging social justice for all" (MFDP, 2009:25). *Botho* is rooted in Botswana culture and promotes the need to be humane or act in a humane manner by showing compassion and charity. Therefore, OVC are to be provided with social protection more for humanitarian reasons than for their right as members of society in need.

Development in the National Development Plans, Vision 2016, NSPR, and the Revised Rural Development Policy is based on the three-pronged strategy associated with the World Bank (WB) and International Monetary Fund (IMF) (Osei-Hwedie, 2007). The approach to poverty is aimed at the promotion of broad-based growth, investment in infrastructure, and social

services to enhance human capacity; and the adoption of social safety nets targeted at the poor and vulnerable (MFDP, 2002, 2003 and 2009). Gil (1992) argues that economic policies, when separated from social policies, reduce them to a residual function. This three-pronged approach is embedded in a residual-neoliberal economic thinking. It has been criticized for not having social protection as a central strategy and excluding the poor from development by not promoting social justice and the equitable distribution of resources (EC, 2010).

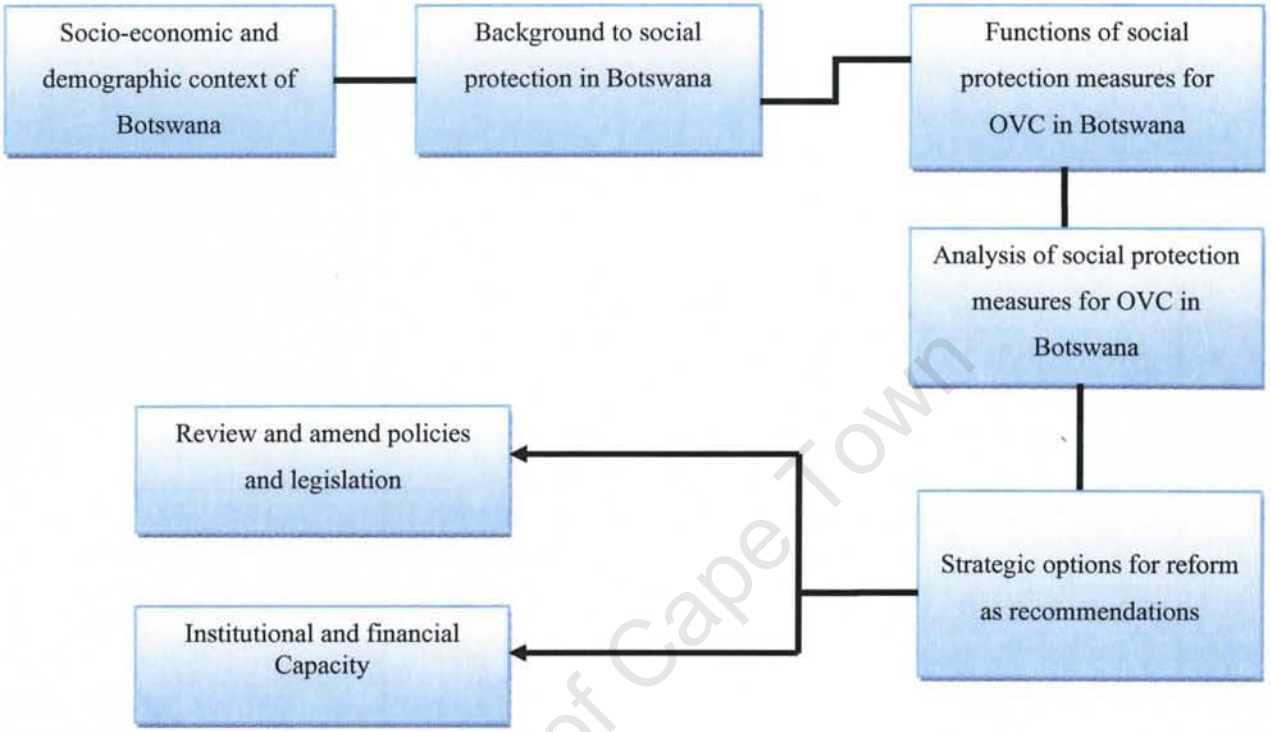
According to Hillbom (2008:193) Botswana has "growth without structural change and development", with "high and unchanging inequalities, poor and neglected rural areas, high unemployment rates, failure in limiting the AIDS epidemic, and discrimination against minority groups such as the San". Hence, economic and social policies need to be complementary so that the investment in children's education and health has a lasting effect in producing human resources that can contribute to growth and in return be reinvested in other people to ameliorate their lives. These values and principles are embedded in a mix of neoliberal, socio-democratic and developmental ideologies. However, in terms of social policy provision the neoliberal approach seems to be more dominant.

1.9 Chapter Outline

Chapter 1 provided the introduction to the study, statement of the problem, rationale of the study, significance of the study, the main question, and sub-questions including objectives and clarification of concepts. It also provided the socio-economic, demographic context and background to social protection in Botswana, and the chapter outline which follows. Chapter 2, which is the literature review, discusses the theoretical models to social policy provision, the socio-economic and demographic context of children and OVC, the functions of social protection for OVC in Botswana, and related studies. Chapter 3 provides the methodology, which includes research design, methodology, data sources, data analysis, ethical considerations, reflexivity and limitations to the study. Chapter 4 is the analysis of social policy responses for OVC, which includes legal and policy framework (Constitution, Children's Act of 2009, National Guidelines on the Care of OVC of 2008, Botswana National Plan of Action for OVC of 2010-2016) and the social protection measures for HIV and AIDS (PMTCT, ART, including CHBC and orphan food baskets). The study concludes with Chapter 5, which presents the findings, conclusion, and strategic options for reform as recommendations.

Overall, this study has been structured in accordance with Taylor's Framework for Social Protection in Africa (adapted in Figure 2).

Figure 2: Taylor's Framework for Social Protection in Africa



Source: Taylor (2008)

Conclusion

Chapter 1 is an overview of the study. It highlighted the problem and the questions that necessitate examining. The chapter also provided the rationale and significance of the study. The key concepts relevant to the research were also clarified. In addition, the socio-economic and demographic context including the background on social protection in Botswana and how they impacted on the well-being of children were discussed. In this chapter, the outline was provided. The chapter concluded by presenting the framework that guided both the analysis of the study and the literature review discussed in the next chapter.

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter provides a literature survey relevant to the study. The key areas to be reviewed are:

- Theoretical models: social policy approaches (residual-neoliberal; institutional-social democratic/conservative, and normative-developmental)
- The socio-economic and demographic context of children and OVC (demographic context; child living arrangements, education, health, and HIV and Aids)
- The functions of social protection provisions for OVC in Botswana (protective, preventive, promotive, transformative, developmental, and generative)
- Related research studies (existing gaps)

2.1 Theoretical Models

For this study, the residual, institutional and normative approaches to social policy responses will serve as theoretical models. The features that distinguish the three social policy approaches are their values, principles, and the ideological perspectives that defines the extent of the state's role in the distribution of resources, most specifically through social provision (Midgley, 2006). These characteristics are viewed as normative explanations for state intervention in social provision, as social policy deals with moral issues such as rights, freedom and equality (Williams, 1989). In addition, the scope of social provision in the three models differs, with the residual viewed as narrow, the institutional moderate and the normative more comprehensive. Each model is influenced by various ideological perspectives that determine what type of provision is available and the adequacy of provision (Taylor, 2010). The different approaches are discussed with reference to the social policy response to OVC in Botswana. As the study focuses on whether the social policy measures are meeting the needs of OVC, the theories of social policy approaches will clarify the appropriateness of the approach that Botswana has taken in the provision of social protection for OVC.

2.1.1 Residual and Neo-Liberal Approach to Social Policy

The residual approach to social provision is influenced by the neo-liberal perspective to social provision. This free market market approach sees social provision by government as the last

alternative when other systems of support are not functioning. Spicker (1995) pointed out that this approach is a safety net for those who are left out of the market and are unable to survive on their own or on their family resources. The features of the residual-neo-liberal approach include: (i) individualism; (ii) minimal state provision and market dominance; (iii) low level of benefits; (iv) low state financing; (v) limited statutory social provision; (vi) efficiency (vii) selectivity (viii) low status of clients (Mishra, 1977; Williams, 1989; George and Wilding, 1994; Spicker, 1995; Patel, 2005 and Taylor, 2010). These features of the residual-neoliberal approach have implications on social provision for OVC in Botswana.

The notion of individualism is that the social problem is explained in terms of individual failure or inadequacy (Williams, 1989). OVC are targeted for social provision without taking into consideration conditions of their caregivers (Ntseane and Solo, 2007). According to Mishra (1977), the role of government in the residual-neoliberal approach is minimal. Patel (2005:22) further suggests that the residual approach holds that "social welfare institutions come into play when the market and the normal systems of support, such as the family and community networks break down". This implies that the government intervenes in social provision when there is no other means of support for those in need. For example, Botswana's destitute policy states that the reason for state social provision was due to "gradual loss of support for poorer members of society within the extended family system" (MLG, 2002:2). However, the government still expects households to support OVC despite their lack of capacity to do so (MLG, 2010).

The minimal role of government and market dominance is embedded in the neoliberal-conservative ideas that postulate that the market should be the driver of the economy and that the "trickle down " approach is the best way to address poverty and meet people's needs through job creation (Patel, 2005). However, the levels of poverty and unemployment in Botswana suggest that the fruits of the economy have not reached those in need. For instance, OVC live in households where their caregivers are unemployed (MLG, 2008a). In addition, the residual-neoliberal approach argues that state social provision encourages people who are able-bodied not to look for employment (Williams, 1989), without acknowledging the failure of the private sector to create jobs. Unemployed young graduates, some of whom were previous beneficiaries of the OVC program, cannot be absorbed into the job market (Seleka et al., 2007) and public social protection is provided to caregivers of OVC.

Critics of the residual-neoliberal model see such an approach as trapping people in poverty, stigmatizing them, and inadequately addressing the structural causes that are impediments to people in accessing social protection (Williams, 1989). Bar-On (2002:27) argues that in Botswana "the residual approach to social security has become a way of mitigating structural social problems". This approach, however, is viewed as inadequate for countries such as Botswana with staggering social indicators of high poverty, unemployment and HIV and AIDS. Therefore, OVC have been left without adequate social provision, risking being trapped in intergenerational poverty.

The low level of benefits refers to provision of bare minimum through low state public expenditure. Botswana's social assistance policies have stipulated minimum provision. Empirical evidence suggests that due to limited calories contained in the food basket, those receiving these baskets are not able to engage in sustained labor (Seleka et al., 2007). This means that the beneficiaries of the destitute program are unable to seek for work that could sufficiently provide for them and OVC who are in their care. Furthermore, non-statutory social protection suggests that social protection is not recognized by the law. Ntseane and Solo (2007) argued that social protection provision in Botswana is mostly provided in guidelines rather than being legislated. For instance, the destitute policy that caters for vulnerable children is not statutory law. This implies that social protection is not recognized as a right. The efficiency principle comes from the belief that the state is wasteful and social provision ends up going to people who do not need it (George and Wilding, 1994). According to Seleka et al., (2007) and Feranil et al., (2010) there have been debates regarding means testing as a possible principle for orphan provision, for reasons of inefficiency. Seleka et al., (2007) noted that some of the informants during the safety nets study argued that means testing should be applied since deceased parents often leave behind assets for their children, while others are taken care of by their surviving parent.

The principle of distribution is selective in that it focuses on channeling resources to those in dire need (Spicker, 1995). Thus the residual selective principle divides the poor from the rest of the society. For example, in Botswana social assistance is provided to groups of people that are viewed as very poor, noted in chapter 1. However, a selective policy is viewed as socially divisive, as those that are meant to access social assistance often do not for fear of being labeled as poor and thus stigmatized (Lister in Alcock et al., 2005). Caregivers of OVC do not register OVC for the same reason – the fear of stigmatization (Tsheko, 2007). With the above-

stated observations from various critics, the residual neo-liberal approach in social protection provision can therefore be viewed as insufficient in meeting the needs of OVC in Botswana.

2.1.2 Institutional and Social-Democratic Approach to Social Policy

The institutional approach came as a result of the limitation of the residual market-based ideas in addressing the problems of the poor. According to Patel (2005:23), the institutional approach is premised on the idea that social provision is a "normal first line function of modern industrial societies" and the idea that the state has a role to play despite the existence of social provision by non-state actors". This suggests that besides government's responsibility in meeting people's needs, other providers can also be involved. This is a move away from the residual approach that sees only government as an alternative social provider when other support systems are crippled. The Social democratic perspective influenced the creation of the institutional approach to social provision. The role of the state in social provision is seen as pragmatic response to social ills in a democratic society, to the need for health care, to poverty or orphanhood (Specker, 1995). The social democratic ideas value the principle of distribution according to ones needs (Mishra, 1977).

The key features of the institutional and socio-democratic approach include: (i) guaranteed civil, political and social rights; (ii) means testing secondary; (iii) equality and equity; (iv) broad availability of statutory social provision; (v) medium level of benefits; (vi) majority of population covered by statutory benefits; (vii) beneficiaries are citizens; (viii) compensates for market failures; (ix) medium state financing; (x) mixed-economy of social welfare (xi) role of state most favorable with other players also able to take part (Mishra, 1977; Williams, 1989; George and Wilding, 1994; Patel, 2005; Sullivan in Alcock et al., 2005; Chagunda, 2006; Taylor, 2010).

The above, referred to as civil, political, economic and social rights, have their roots in Marshall's notion of citizenship rights and are important elements of state social provision in a social democratic government (Mishra, 1977). The civil and political rights are seen as enablers for citizens to claim social provision, which is entrenched in the social and economic rights (Sullivan in Alcock et al., 2005). According to Mishra (1977), civil rights are concerned with individual liberty and equality before the law, with political rights primarily concerned with participation in the political process of government. Although the Children's Act of 2009 promotes civil and political rights, the social and economic rights are not enforceable in the court of law (Botswana Government, 2009).

Within the institutional and social-democratic approach, the role of state social provision goes beyond relief, but solving the problem of redistribution and access to social assistance through universal access (Mishra, 1977). This universal access principle means that everyone should have access to social provision such as education, housing, health care and income security (Patel, 2005). The STPA targeted provision to all orphans that are citizens of Botswana (Tsheko, 2007). However, not all the orphan's have been reached (MLG, 2008a).

According to George and Wilding (1994), universal provision is preferred as means-testing is perceived to be costly with low up-take due to stigma. It is argued by Tsheko (2007) that the caregivers of OVC and potential beneficiaries of the CHBC do not register as the programs are associated with people with HIV and AIDS, a status that still has great stigma attached to it in Botswana. Compensation for failures in the market means that when economic growth, driven by the private sector, falls short of benefiting the poor through job security, those that are left jobless feel the negative economic effects (Titmus in George and Wilding, 1994). As such, social protection provided by government will be there to address the negative effects of the economy on the poor and unemployed. The Botswana government is the main financier for OVC social provision, (Botswana Government and UNAIDS, 2010) but does not provide social protection for people who have lost their jobs (BFTU, 2007). This means that children who become vulnerable to such impacts are left without social protection, except for those viewed as very poor (MLG, 2002).

Both the residual and institutional models have been criticized for not being appropriate for developing countries (Midgley, 2006). The reasons advanced are that the residual approach failed to considerably reduce poverty and led to inadequate access to social provision such as health, education, and housing (Mishra, 1977, Jonsson, 2003 and Taylor, 2008). Most OVC in Botswana live in poverty-stricken homes due to the lack of gainful employment of their caregivers (MLG, 2008a). In addition, the high benefits and extensive coverage of a population by the institutional provision, mostly associated with Western Europe, were viewed as unsustainable, particularly for countries in Africa with such low economic growth (Midgley, 2006). Hence, the normative approach was designed as the third model.

2.1.3 Normative and Developmental Approach to Social Policy

The normative approach is underpinned by the development perspective and differs from the residual and institutional approaches in terms of values and principles that guide social policy

provision. According to Mishra (1977) the normative approach is premised on needs-based distribution and in ensuring that needs are met through government intervention. The developmental perspective is grounded on democratic values, social justice and human rights (Taylor, 2010). In this approach, social provision should not only be available, but provide equitable access and equal opportunity to attain social justice as well as provide adequate minimum standard of living particularly for the vulnerable and marginalized (Patel, 2005). The most prominent features of the normative approach to social policy provision include: (i) high state intervention; (ii) need-based distribution; (iii) availability of comprehensive statutory service institutions; (iv) all population covered by statutory social provision; (v) adequate benefits and high status of beneficiaries; (vi) universal access; (vii); orientation of services is to bring social harmony (viii) the principle of equity is prominent; (ix) social policy influences economic policy (Mishra, 1977; Williams, 1989; Midgley, 1995; Patel, 2005; Chagunda, 2006; Taylor, 2010).

The high state intervention is favored with substantial share of government revenue spent on social provision (Patel, 2005). In the normative approach, the institutions that provide services are recognized by law which also protects the beneficiaries who can claim social provision as a right, since it is legislated. (Mishra, 1977). In addition, the level of benefits provided is high and universally accessible to enable fair distribution and to bring solidarity within society (Mishra, 1977). Through redistribution and regulation this offset the inequalities that are created by the private market in order to aim for a more just and harmonious society (Titmus in George and Wilding, 1994). The reason for such state control over the market is for social policy to make the economic policy socially responsible (Williams, 1989).

As argued by Midgley (2006), the residual and institutional approaches assume that social provision will be met through revenue generated from the economy, but falls short of clearly addressing the developmental issues. Midgely (1995:25) defines the developmental approach, which he refers to as social development, as the "process of planned social change designed to promote the well-being of the population as a whole in conjunction with a dynamic process of economic development". Thus, developmental perspective requires integration of economic and social policies. According to Midgley (1995) by harmonizing social policy and economic policy this enables revenue from growth to both address poverty and improve poorly performing social indicators, such as in health and education. Thus, investments in human development is critical to address the inequalities created by economic policies that do not

translate into social improvements. Therefore, the capacities of the poor can be enhanced through participation in productive economy through education and skills development as most effective way of advancing economic goals and people's welfare (Patel, 2005). This suggests that OVC can be viewed not only as beneficiaries of growth but also as potential resource and social investment that can boost the economy. Therefore, the state tries to guard against a society where some people are further disadvantaged, thus leading to gaps in accessing the needed social provision.

Patel (2005) argues that the developmental approach recognizes that people are excluded from any minimum standard of living, access to social provision and opportunities and therefore calls for fair distribution of benefits so that needs of people are met through social protection. Caregivers of OVC have no source of income or have income less than the average monthly earning (MLG, 2008a), which is currently P4, 120 or US$ 685 (CSO, 2010) and not enough to sustain a household. This means that the unfair distribution of benefits impacts on the standard of living of OVC.

In view of the fact that the socio-economic status of OVC means that they lack access to education, health care and food security, the normative and developmental approach would be appropriate to address their needs. The government's approach to social provision is for the most part, not based on the normative approach. In addition, the socio-economic status of the people also gives an indication that the government's approach to social provision is not developmental.

2.2 Socio-Economic and Demographic Context of Children and OVC

2.2.1 Demographic Context

The number of children under the age of 18 is estimated to be 77 900, reflecting 34.9% of the country's total population (UNICEF, 2011). The child population shows a reduction in 1991 from 51% to 44% in 2001 in the last published census (CSO and UNICEF, 2005). This could be due to the decline in adult fertility and deaths amongst children from HIV and AIDS-related illnesses and other diseases. The last estimates of spatial distribution were in 2001, with 52% of the children living in rural areas and 48% in urban areas (CSO and UNICEF, 2005). According to CSO and NACA (2009), young people between the ages of 15 to 29 live in urban areas, whilst infants and children below the age of 14 are mainly found in rural female-headed households, before moving to urban areas as they get older in search of job

opportunities. Almost a quarter of the child population is under the age of five (224 000) of the total population of Botswana (UNICEF, 2011).

Table 2: Socio-Economic and Demographic and Trends (Children)

Indicators	Socio-Economic and Demographic Trends		
Population (0-18)	670,323 (1991)	737 ,241 (2001)	779,000 (2011)
Population (urban) / (rural) %	39.3/ 60.7 (1991)	48 / 52.2 (2001)	
Net Enrolment Primary Education (6-12)%	88 (1990)	89 (2005)	86.9 (2010)
Underweight (under-Five) per 1000	17(1996)	13(2000)	13.5 (2010)
Stunted (under-Five) per 1000	29 (1996)	23 (2000)	26 (2010)
Wasted (under-Five) per 1000	11 (1996)	5 (2000)	7.2 (2010)
Under-Five Mortality per 1000	66 (1991)	73 (2001)	57 (2009)
Infant Mortality per 1000	48 (1991)	55(2001)	43(2009)
Child Mortality per 1000	17(1998)	19 (2001)	26 (2006)
Infants born to HIV infected mothers %	20.7 (2003)	11.5 (2005)	3.8 (2010)
No Access to Immunisation (12 months)%		55(2004)	10 (2010)

Source: Botswana Government and UNDP (2010); CSO (2008, 2009 and 2010); CSO and UNICEF (2005); UNICEF (2011); and Botswana Government and UNAIDS (2010)

2.2.2 Child Living Arrangements

The current child living arrangements are different from what they used to be in the traditional setting. The social changes attributed to migration and HIV and AIDS, altered the family and social structure that used to exist and cared for needy children. According to CSO and NACA (2009), of the children's population, of those who live with their mothers is 39%, with only 3% with their fathers and 58% shared equally between both parents and guardians. Most children in Botswana live in rural female-headed households.

In the early 1970s, as a result of the migration of men – mostly rural – to South Africa to work in the mines, women were left with the sole responsibility of taking care of the needs of their family and children (Kossoudji and Mueller, 1983). Some of these migrant men occasionally sent remittances home, while others simply never returned home. This fuelled the emergence of the single-female-headed households which are now trapped in rural poverty with limited income-earning opportunities to provide for themselves and their children. HIV and AIDS has further exacerbated the situation, leaving children in the care of grandparents who are in need of support themselves, hence unable to provide for their grandchildren (CSO and NACA, 2009). In other cases, older children have assumed the role of being parents to, and caring for, their younger siblings (MLG, 2008a).

2.2.3 Education

Despite significant improvements in education in Botswana, there are trends that reveal gaps. The combined literacy rate of adults 15 years and above is 84.8% (UNDP, 2010). According to Throupe (2011), only 35.9 % of children in the 1970s completed primary school. Currently, Botswana is reported to have achieved universal access to 10 years of basic education (Botswana Government and UNDP, 2010). In Botswana, primary enrolment is understood in terms of two categories of children's age groups, notably, 6 to 12 years and 7 to 13 years. According to the Botswana Government and UNDP (2010), many parents, particularly those in rural areas, do not send their children to school before the age of 7 years, and these children rarely make it into pre-school.

It was further reported by CSO that primary school enrolment for children aged 6 -12 years is estimated at 331 195, making it 89.4 % and for those 7-13 years, 90.8% of those that are supposed to be in school (CSO, 2010). This shows that primary school-going age children, who are meant to be in school but are not, account for approximately 10%. In terms of secondary school enrolment, there is no difference between OVC and non-OVC. According to MLG (2008a), "the male OVC 13-17 years, 99.5% had attended school and 85.2% were currently enrolled". An education deficit of 15% is too high and Education International (2009:1) argued that "since 2007 more than 1331 students were locked out of school because their parents cannot pay". This implies that there are children who are excluded from education, with possible impact on their future ability to provide for themselves and their families.

According to CSO (2010) between 2009 and 2010 the number of children that had dropped out of school was 3195. It had been observed that most of the drop-outs were boys in comparison to girls, who accounted for 65% (CSO, 2010). Two factors contributing to the lack of retention of children in school were reported as: schools being too far away for children to easily access them, and the fact that parents consider their children to be too young to go to school (CSO, 2010). The high school drop-out rate of boys than girls is not surprising. Boys growing up in cattle posts and remote settlements find it difficult to attend school as they are often far away from them. This can result in them shouldering their parent's responsibilities of taking care of cattle for the rich families who pay them very little and risk being trapped in intergenerational poverty. Those children, who reside in settlements where population groups are semi-nomadic or come mainly from the ethnic *Basarwa,* often drop-out

because of language barrier and seasonal livelihood activities of hunting and gathering to feed their families (Botswana Government and UNDP, 2010).

According to CSO (2010) secondary school enrolment in 2009-2010 was 171 986, with 51.9% being females. However, the drop-out rate was 3569, of which 61.1 % were females mostly at the level of Form Two, which is the last year of junior secondary education before one proceeds to three year of senior secondary schooling at the age of 15-16 years. In secondary school, pregnancy has been observed as the main driver for girls leaving school, and some of them are HIV positive (Botswana Government and UNDP, 2010).

2.2.4 Health and HIV and AIDS

Despite children feeling the effects of other diseases, HIV and AIDS has brought with it severe ramifications. Children in Botswana continue to get infected by HIV virus regardless of a decline between 2004 and 2008. Infection rates among children between the ages of 18 months and 4 years dropped from 6.3% in 2001 to 2.2% in 2008, with the 10 and 14 years still hovering around a 3% (CSO and NACA, 2009). The factors that have contributed to children being infected are: the transmission of HIV from mother to child, unprotected sex and sexual abuse. Notwithstanding progress made in preventing HIV infection among children, the data shows that they are still vulnerable to HIV.

Table 3: HIV Prevalence and Incidences among Children

HIV Prevalence and Incidences by age (%)	2004	2008
1.5-4	6.3	2.2 / 1.59
5-9	6.0	4.7 / 1.53
10-14	3.9	3.5 /1.04
15-19	6.6	3.7 / 3.22

Sources: CSO and NACA (2009) and Botswana Government and UNAIDS (2010)

The rate of infection amongst pregnant women has implications for children. According to the WHO (2007), mother-to-child transmission of HIV can take place during pregnancy, labor, delivery or breastfeeding. Thus, an HIV positive woman can put her unborn and infant child at risk of contracting the virus. The child's survival is also dependent on the health of the mother. A mother that is not healthy will not be able to give adequate care to her child, and this in turn may affect the child's chance of survival. The HIV infection rate among pregnant women is the highest in the country. The trend shows that rural women are now getting infected at a higher rate than those in urban areas, who already carry the burden of unemployment and poverty and limiting their ability to care for OVC. In Table 4, the data

derives from the 2009 Botswana Second Generation HIV Antenatal Sentinel Surveillance Technical Report, which provides the estimates for HIV prevalence among pregnant women (MOH, 2009). However, the inconsistencies regarding the total percentage of urban and rural areas are not explained in the report.

Table 4: HIV Prevalence among Pregnant Women (15-49)

Indicator	2001	2002	2003	2005	2006	2007	2009
Prevalence among Pregnant Women (15-49) %	**36.2**	**35.4**	**37.4**	**33.4**	**32.4**	**33.7**	**31.8**
Residence							
Urban	**51.4**	**51.2**	**54.6**	-	**33.9**	**34**	**32.4**
Rural	**49.7**	**45.9**	**46.9**	-	**34.6**	**36.7**	**33.1**
Age							
15-19	**24.7**	**21**	**22.8**	**18.1**	**17.5**	**17.2**	**13.2**
20-24	**38.7**	**37.4**	**38.6**	**31.2**	**29.4**	**27.9**	**24.1**
25-29	**48.4**	**50**	**49.7**	**44.5**	**42.8**	**39.7**	**36.2**
30-34	**44.1**	**46.7**	**45.9**	**49.2**	**48.7**	**50.3**	**49.1**
35-39	**39**	**36.2**	**41.5**	**40.2**	**42.7**	**47.8**	**50.7**
40-49	**26.9**	**28.8**	**34.4**	**30.4**	**27.4**	**35.2**	**40.8**

Source: MOH (2009)

The current child mortality indicators reveal high rates, especially among under-fives, despite a slight downward trend. According to UNICEF (2011), under-five mortality was at 66/1000 in 1991 and rose to 73/1000 in 2001. It currently stands at 53/1000, which is too high, especially in comparison with other countries such as Brazil (21/1000) that are at similar economic levels (UNICEF, 2011). Similarly, the infant mortality had risen to 55/1000 in 2001 from 48/1000 in 1991 and is now estimated to be 43/1000 in 2009 (UNICEF, 2011). Deaths amongst children are attributed to HIV and AIDS and other diseases, such as pneumonia and diarrhea (CSO, 2010).

An estimated 10% of children aged 1 to 2 are not adequately immunized (Botswana and UNDP, 2010). A country wide outbreak of "diarrhea epidemic" was reported by MOH in the Press Release of August 2011 (MOH, 2011b:1). In addition, on the 15th of September 2011 the local newspaper, *Mmegi*, reported that during the MOH press conference, 5580 diarrhea cases were reported among children under-five, including 67 deaths (Moeng, 2011). This was the second outbreak, with 20 000 cases of infections, including 450 deaths reported in 2006 (Moeng, 2011). In both of these epidemics, the lack of government provision of rotavirus vaccination for immunization which prevents was reported as the source of the problem (Moeng, 2011). This suggests that, had the government provided the rotavirus immunization,

which prevents diarrhea amongst children, this could have averted some of deaths. All the above health problems pose a challenge in terms of child rights and human development, as every child has a right to survive and develop.

According to Econsult (2006), HIV and AIDS put a strain on household income, especially on that of the poor, by reducing it by 50%. Other costs felt by households due to HIV and AIDS include either death of the bread winner, or their inability to work due to ill health. Also, days before the actual burial, family, friends and community members are fed when they come for prayers. This means that for poor families the limited resources they have are diverted to other needs associated with the funeral and burial, leaving households and children with not enough money to cater for the basic needs. Furthermore, households have to pay for the chronically ill, particularly transport and special dietary requirements (Econsult, 2006). Adult deaths also means that the number of income earners is reduced, limiting provision for dependent children.

2.2.5 Orphans and Vulnerable Children

HIV and AIDS have increased the number of orphans over the years. According to CSO and NACA (2009), children that have lost one or both parents increased from 34 450 in 2004 to 111 567 in 2008. It is also important to note that the 2005 estimate focused on children up to 18 years, whereas the 2008 focus is 17 years and under. Evidence suggests that more children lose their fathers (67 653), double orphans account for 29770, and living maternal orphans account for 14 144 of the total number of orphans (CSO and NACA, 2009).

Table 5: Orphan Indicators

Indicator	2001	2004	2008
Number of Orphans	111,828 (15.2)%	125,234 (0-18) (16.7%)	117,.567(0-17) (16.2%)
Double Orphans	-	23,260	21,990
Single Orphans	-	101,974	95,577
Urban		15.8%	15.2%
Rural		17.7%	17.3%

Source: CSO and NACA (2005 and 2009)

In addition, children live in households with providers that are in poor health. According to CSO and NACA (2009), an estimated 29,321 of guardians and parents were bedridden in 2008, with 50% between the ages of 25 and 49, and 50.2% accounting for those living in rural areas and with children .

The poverty and vulnerability of children is dependent upon the living conditions in the households where these children reside. Children that live in households where poverty is present are likely to experience poverty themselves. MLG (2008a) argues that 36.9% of the children live in households where the head is unemployed. Other heads of households had temporary jobs with income less than the average monthly earning of US$ 685 (CSO, 2010), a situation which is further exacerbated by lack of skills and education.

2.3 Functions of Social Protection Provision for OVC in Botswana

Taylor (2008) argues that a comprehensive social protection policy has five functions, aims and measures. The five social protection functions considered as adequate to respond to poverty, vulnerability and risks are: (i) protective; (ii) preventive; (iii) promotive; (iv) transformative; and (v) developmental and generative (Taylor, 2008). These five functions of social protection are critical as the problems of poverty, including risks and vulnerability to HIV and AIDS, still continue to be present in the country and to impact on OVC. The relevance of the functions of social protection measures are discussed in relation to OVC in Botswana.

The first three functions – protective, preventive and promotive – are in the ILO framework originating from the ideas of Guhan (Ellis et al., 2009; UNICEF, 2008). The protective function is when social measures, such as emergency relief in the form of food, feeding schemes in schools and clinics, HIV treatment and care, and social assistance in the form of cash transfers to children, the elderly and people with disabilities, are introduced to save lives and reduce deprivation in a society (Taylor, 2008:52). As an immediate response to the HIV and AIDS crises, government provided food basket for orphans and AIDS treatment for children (Tsheko, 2007). These were meant to play a protective role to save lives and lessen deprivation.

According to Devereux (2006) welfare safety net programs dominate policy response to risk and vulnerability, despite the interventions not being comprehensive. Similarly, Taylor (2008) asserts that safety nets are not designed to address structural conditions such as those that mark Africa's socio-economic context. This view is further shared by Sabates-Wheeler and Devereux (2006:1), who comment that social safety nets are not considered unimportant but that they are "not enough without a complementary focus on structural causes of vulnerability and attention to the social and political dimensions; as such assistance can be viewed as

serving a protective function". This suggests that the administrative constraints that hamper access to health, such as language barrier for *Basarwa* children, need to be addressed.

The preventive function seeks to "assist people from falling deeper into poverty or becoming vulnerable to risks and contingencies arising from natural disasters, crop failures, accidents and illness" and programs are designed to achieve preventive objectives which include support to community disaster management projects, subsidies to farmers, unemployment and health insurance, and support to community saving schemes, as well as basic social services, health care and education (Taylor, 2008:40). The STPA of 1999, catering for orphans and the Revised National Policy on Destitute Persons, which includes vulnerable children, had preventative measures to exempt OVC from paying health and education fees in order to avoid exacerbating their already impoverished situation (MLG, 2008a). Despite government putting in place preventive measures for OVC, children in remote areas still lack access to education and health (Botswana Government and UNDP, 2010).

The promotive function is aimed at enhancing the capabilities of the individual, communities, and institutions to participate in all spheres of activity with measures that promote the well-being of all, such as school feeding schemes, participating in public works programs to create community assets and social infrastructure, and conditional cash transfers that require children to be sent to school and to the clinic (Taylor, 2008). This function deals with productive investment in the poor, enabling stable earning, the building of skills capacity, and the accumulation of asserts, thus allowing for long-term, pro-poor growth. For example, the government provides children in public primary and secondary school with one cooked meal per day with remote area dwellers receiving an extra meal (RHVP, 2011). This suggests that the aim of food provision is to ease short-term hunger to enable children to learn while they are at school, but it is not clear how long-term food insecurity at home will be addressed.

The transformative function, inspired by Sabates-Wheeler and Devereux (2004), is the fourth of these. It is aimed at enhancing the social rights and status of vulnerable and marginalized groups by removing barriers to their social, economic and political inclusion through changes in policies, laws, budget allocations and redistributive measures (Taylor, 2008). The role of social protection there is linked to the rights-based argument. It sees social protection as a right and entitlement, and is concerned with social inequity and the exclusion of, in particular, vulnerable and marginalized groups (Taylor, 2008). According to OECD (2009:26) "the rights-based and transformative approach to social protection reinforces empowerment by

ensuring that vulnerable groups have the capacity to benefit from and contribute to growth and participate fully in the society". There is evidence to suggest that *Basarwa,* who mostly reside in remote areas, are socially, economically and politically marginalized (Good, 1999; Nthomang, 1999; MLG, 2003; Thapelo, 2003; ACHPR and IWGEA 2008; Bojosi, 2009 and UNGA, 2010). Those who dwell in remote areas are poor, lack access to basic social services such as education, health, employment opportunities, and are not included in the decision-making processes (Nthomang, 2004).

The UN special rapporteur on indigenous people also observed discrimination by service providers towards remote area communities (UNGA, 2010). In addition, government spending in these areas is still a challenge. Ntseane and Solo (2007) argued that the budget allocations for the Remote Area Development Program (RADP), which includes OVC provision through the destitute policy and orphan care program, is often not enough to cover all food items in the food basket (Ntseane and Solo, 2007). According to UNICEF (2008:3) "the rights of the poorest and most vulnerable should be explicitly incorporated in the social protection system". The lack of guaranteed social protection can lead to the inability of the poor to claim their rights, making them more vulnerable and thus leading to their exclusion from development and the perpetuation of their poverty.

The RADP has also been criticized for lack of strong political support, mainly for being short of legislative backing (MLG, 2003). This is consistent with the findings of the review of the RADP in 1978, which pointed to the implications of the lack of political and legislative support for social provision. According to MLG (2003: 9), the review concluded that the remote area people's rights to social provision were not attainable as they were "not entrenched and could well prove ephemeral in the absence of a firm political support". This was more evident when the government withdrew RADP social provisions in the CKGR in 2002 and was not found to be in the wrong by the court (ACHPR and IWGEA, 2008). The ILO report (2010) contends that if the social transfer is not adequate, this can mean that the needs of the poor are not met. OVC were therefore affected by the withdrawal of the government's social assistance in the CKGR. With the above problems affecting remote area dwellers who are mainly *Basarwa*, it can be argued that social provision for marginalized *Basarwa* children is not transformative as it does not enhance their rights and status.

Lastly, the fifth function brings together the linkages between the human development and Sen's capability approaches and the generative aspect from Kabeer (Taylor, 2008). The

objective of the developmental and generative role to social protection is not only for the poor and vulnerable groups but also to increase capabilities and opportunities whilst contributing to economic growth and promoting human development (Taylor, 2008). Therefore social protection is not only to increase the consumption patterns of the poor, but to boost local economy particularly in rural areas and enable the poor to have access to social and economic opportunities, while at the same time breaking the intergenerational transmission of poverty (Taylor, 2008). According to Samson et al., (2006) a cash transfer is seen as an incentive to seek for employment. The caregivers of OVC are not provided with any income support by government (Feranil et al., 2010). This means that caregivers are not able to search for jobs to adequately provide for OVC. Therefore, it can be argued that the government does not address the long term needs of OVC to escape intergenerational poverty.

The five functions are therefore aimed at contributing to growth by enhancing equitable access to social and economic opportunities, whilst at the same time building capabilities and averting and relieving deprivation that causes poverty. This suggests that social protection measures can serve different functions, and cash transfers in particular can serve many needs. In addition, health, education, food and nutrition are important social opportunities and important investments to improve the development of the children as future contributors to the country's economy. Although Taylor's functions of social protection can be viewed as comprehensive, there are some authors who find that the broad conceptualization of social protection makes it difficult to establish the parameters of social protection and development policy (Oduro, 2010 and Ellis et al., 2009). Similarly, Page et al., (2005:1) pointed out that social protection "is not intended to promote economic growth". However, Taylor has clearly shown its relevance to the socio-economic context of Botswana, especially in relation to OVC, and therefore remains appropriate to the country.

2.4 Related Research Studies

The study also looks at other related research studies that have been undertaken on OVC in Botswana and identifies existing gaps. Evidence of the most recent study suggests that there is limited literature on social protection in Botswana. In his foreword, Edwin Kaseke noted that Ntseane and Solo's analysis was the first attempt to provide a comprehensive review of existing social security system in Botswana (Ntseane and Solo, 2007). The analysis was undertaken in 2007 to better understand social safety net schemes that exist in Botswana. The study concluded that social protection in Botswana was not inclusive and comprehensive. Although social assistance to OVC was also included in the study, the data is outdated and the

study does not address the inadequacy of the HIV and AIDS social assistance provision, particularly when using the Taylor approach.

According to Miller et al. (2007), most literature on OVC in Sub-Saharan Africa especially countries that are severely impacted by HIV and AIDS focus on their socio-economic situation. This is not surprising in the case of Botswana, which has one of the highest infection rates in the world. The 1999 *Rapid Assessment on the Situation of Orphans and Vulnerable Children* was the first study to be undertaken and was the bases for the development of the STPA (Muchiru, 1998). The study highlighted the lack of access to basic needs such as food and shelter, the violation of human rights, and the neglect and insufficient provision of care (Muchiru, 1998). The 2007 S*ituational Analysis of OVC* also observed that OVC lack access to health, education, and health as a result of their household's living conditions (MLG, 2008a).

There are other studies that have been undertaken to determine the situation of OVC in Botswana (Tsheko et al., 2006); Miller et al., 2007; Tsheko, 2007 and Tsheko et al., 2007). These studies, despite being confined to few districts, tried to get an in-depth knowledge of the magnitude and problems of OVC on the ground. The major findings were that the number of orphans registered for government support was unclear; poor families had challenges in catering for the needs of OVC such as food, clothing, education, decent housing; and that a great number of orphans were also infected with HIV. Miller et al., (2007) further suggested that the allocation of resources was amongst the possible factors impacting on the health of orphans. These studies did not provide adequate analysis of issues related to OVC in relation to social policy, especially social protection measures.

The *Baseline Study on Psychosocial Support of Orphans and Vulnerable Children in Two Villages* focused on psychosocial provision, which was found to be inadequate, and recommendations were made to strengthen the area (Tsheko, 2007). Although the research outlined the problems to be addressed, the role of government was not examined. The most recent studies have also focused on project-based studies to evaluate the implementation of OVC programmes. The evaluation by Feranil et al., (2010) *Assessing Implementation of Botswana's Program for Orphans and Vulnerable Children* highlighted the issues of human resource capacity, the lack of dissemination of policies, and the weak monitoring system. Similar to other research studies, the analysis had limited focus on social protection.

Another study by Formson and Forsyth focused on the cost of OVC social assistance provision by NGOs and one government institution, and concluded that the current response in respect of OVC is insufficient to have the required impact, due to lack of resources (Formson and Forsyth, 2010). Despite the extensive research done on OVC in Botswana and the ability to elaborate on social and economic conditions as well as institutional barriers, the studies fall short of linking social assistance for OVC to the new thinking of social protection as a comprehensive approach in responding to issues dealing with groups that are affected by structural poverty, vulnerabilities and risks such as HIV and AIDS. In this study the intention is threefold. First, it is to expand the understanding and knowledge of the impact of HIV and AIDS on OVC in Botswana by building on previous research. The second aim is to provide an integrated analysis of existing social provisions for OVC, and finally the study aims to draw attention to the gaps in provision and to make recommendations on how these can be addressed.

Conclusion

In this chapter, I have discussed the main social policy approaches and the political ideologies that influence the extent and adequacy of social provision in relation to OVC. Social policy provision for OVC in Botswana is mixed with the residual-neoliberal approach emerging as more prominent. This is despite the risks and vulnerabilities such as HIV and AIDS, poverty and unemployment that continue to affect OVC. In addition, the socio-economic and demographic context of OVC is discussed in relation to the risks and vulnerabilities they face. HIV and AIDS have had a major impact on OVC making them more vulnerable to poverty and a lack of access to basic services. The functions of social protection for OVC are geared towards social assistance, playing a more protective role with the exception of social services such as health and education that have an element of preventive purpose.

CHAPTER THREE
METHODOLOGY

3.0 Introduction

To achieve the objectives stipulated in Chapter 1, this chapter presents the research design, methodology, ethical considerations, reflexivity and limitations to the study. The research design provides an overview of the relevance of the research strategy that has been used in the study. This is then followed by the methodology, which explains the data sources and the approach used in the data analysis. The chapter then proceeds with a discussion on the ethical considerations that guided the study, noting how the study has not been compromised. Reflexivity, as the subsequent discussion, illustrates the researcher's own biases to the study. Lastly, the limitations to the study are discussed to note the shortcomings encountered during the study.

3.1 Research Design

According to Leedy and Ormrod (2010), a research design is a strategy that outlines the manner in which the researcher intends to address the research problem. As stated in Chapter 1, the Taylor frameworks on social protection in Africa and the analysis of social policy have been adopted as pre-determined models to structure and guide some of the research questions, review and analysis. Both frameworks were adopted as they apply to the African context and to the continent's historical and structural deprivations. The frameworks are also appropriate in the context of high rates of poverty, unemployment, and the devastating impact of HIV and AIDS. Both frameworks have been adopted and modified to make them relevant to the study.

The nature of this study is exploratory. According to Babbie and Mouton (2009), exploratory studies are most common when there is an enquiry into new areas of interest and persistent phenomena. Taylor (2008) argues that social protection has currently emerged as a comprehensive policy, particularly in Africa, to address persistent problems including poverty and vulnerabilities such as HIV and AIDS. Despite research being conducted with regards to OVC in Botswana, the social protection policy perspective and its relationship to social policy is still limited. Therefore, an exploratory method is appropriate for this study in gaining new insight into the issue of social protection in relation to the continual problem of HIV and AIDS as it impacts OVC in Botswana.

In addition, Babbie & Mouton (2009:80) summarised key reasons for undertaking exploratory studies. These are: "(1) to satisfy the researcher's curiosity and desire for better understanding, (2) to test the feasibility of undertaking a more extensive study, (3) to develop the methods to be employed in any subsequent study, (4) to explicate the central concepts and constructs of a study, (5) to determine priorities for future research, and (6) to develop new hypothesis about an existing phenomenon". The relevance of these reasons to the study is explicated below.

Firstly, Taylor (2008) asserts that social protection measures have an important role to play, particularly in protecting the vulnerable and enhancing the social status and rights of socially excluded and marginalised groups. Therefore, the researcher found it imperative to get a better understanding of social protection practice in Botswana regarding OVC whom are a disadvantaged group. Most specifically, the analysis of the study seeks to understand whether the social policy measures are addressing the needs of OVC.

Secondly, the analysis does not broadly look at all the social policy measures for OVC, but focuses on social protection for HIV and AIDS. Therefore, there is room to build on this study for more elaborate studies. Thirdly, the study relies mainly on literature review. Babbie and Mouton (2009:80) suggest that literature review is amongst the methods that may "lead to insights and comprehension". Fourthly, the study presents the relationship between key concepts of social policy, social protection and social assistance adopted from Taylor (2008). These concepts provide clarity to the type and role of measures that are being provided to OVC. Fifthly, as stated above, the study is limited to literature review and therefore there is room for further studies with a possible inclusion of empirical primary data sources such as interviews to get perspectives of beneficiaries and policy makers. Sixthly, as social protection is an emerging issue, new assumptions can be explored, as it is the case with the present study on OVC in Botswana.

3.2 Methodology

According to Babbie and Mouton (2009), methodology deals with the way in which data will be collected and analysed according to a particular research design and the research problem involved. This study uses a desktop method and reviews a mix of existing qualitative and quantitative secondary data. Whereas quantitative research is differentiated by using statistical information, qualitative study seeks to describe and understand social action (Leedy and Ormrod, 2010), which is difficult to obtain or explain from quantitative analysis. Secondary

data, on the other hand, refers to data that has been collected and made available by a primary source (Leedy and Ormrod, 2010). Although, it has the advantage of saving time and costs, the disadvantage is the issues of validity and relevance to the researcher's study (Babbie and Mouton, 2009). This was important for this study as the researcher seeks to understand whether the existing social policy measures address the needs of OVC.

The conceptual framework for social protection in Africa has been adapted to the study for both the literature review and analysis (see Figure 1 in Chapter 1 for the modifications). The Taylor framework (Taylor, 2008) focuses on the background of social protection, the prevailing socio-economic demographic conditions of the country, clarification of its nature, the values and principles functions that underpin social protection programs, and the challenges that exist. It then provides strategic options for reform as relating to policy and legislation; program design issues and financial and institutional capacity. The data sources have been provided for the review and questions for the study.

3.2.1 Data Sources

Quantitative Data

To provide a macro-level socio-economic and demographic context of Botswana, and that of OVC in the country, quantitative data was used from a variety of sources. The statistical data was derived from relevant national surveys including the BAIS II and III, the 2007 Botswana Family Health Survey, the 2006 Botswana Demographic Survey, and the 2005/2006 Botswana Labour Force Survey. In addition, published data was obtained from national and global reports produced by organisations such as the Botswana CSO, NAC, and NACA including WB, IMF, WHO, UNAIDS, and UNICEF.

Qualitative Data

Qualitative data were derived from the review of three main sources:

i. Relevant policy, legislative, operational, and other government documents related to OVC and social policy and social protection in Botswana. These included: Constitution of the Republic of Botswana, Children's Act of 1980, Children's Act of 2009, 2008 National Guidelines on Care of OVC and Botswana National Plan of Action for OVC 2010-2016, Vision 2016 document, National Development Plan 10, NSPR, the Revised National Rural Development Policy, the Short-Term Plan on Care of Orphans, the 2008 National Guidelines on Care of OVC, the NPA for OVC of

2010-2016, and various HIV and AIDS treatment guidelines. The aim of this review was to obtain a deeper understanding of the current frameworks for commitment, policy, and programme implementation, and thus to address Objective 1 of the study.

ii. Relevant research studies, evaluations, and situational analyses of OVC in Botswana, from national, regional and international organizations such as CSO, BIDPA, MLG, MOH, NACA, AU, SADC, and UN agencies. The aim of this review was to assess the socio-economic and demographic context of children and OVC, and hence to address objectives (2) and (3) of the study.

iii. Current empirical literature review to assess the scope of knowledge on social policy and social protection practice in Botswana and that of OVC in the country. Theoretical frameworks on social policy, social protection and social assistance were also reviewed. The aim of this literature review was to assess current knowledge about the social assistance for OVC in Botswana, as well as the functions of social protection provision for OVC in Botswana. The literature review addressed objective (4) of the study.

3.2.2 Data Analysis

The frameworks for analysing the social policy response for OVC adopted for this study were attained from the Taylor framework on social protection for Africa (Taylor, 2008) and the Taylor approach to social policy analysis (Taylor, 2010). These two frameworks are to complement each other in this study. Taylor's approach to policy analysis concerns seven aspects "common to most types of social policies" with the questions that highlight both the "theoretical approaches and techniques in social policy" (Taylor, 2010:1). These aspects include:

(1) The social need /social problem
(2) Analysis of the social policy;
(3) Side effects within the society;
(4) Side effects outside the society;
(5) Possible alternative approaches;
(6) Implementation, monitoring and evaluation of the policy; and
(7) Proposing recommendations.

The various aspects of the framework can be used as needed. This study thus used the first, second and last aspects (identification of the need or problem that the policy seeks to address, analysis of social policy, and proposing recommendations). These aspects also entail several questions as shown in below (Taylor, 2010:1):

Social need/social problem

(1) What are the specific social needs/problems which the policy aims to meet/resolve?
(2) What is the history of this problem/need?
(3) Is there a widespread agreement about what are the needs and problems?
(4) Indicate the key people/organisations/stakeholders involved in lobbying for against or against resolution of the problem
(5) What are their views of the problem/need and what/whose interests are represented in these views?
(6) What is the socio-economic context of the country, region or group? Provide demographic trends and indicators.
(7) What are your views about the root causes of this problem/need and does any research evidence back up your views-use any data/evidence to do this? Discuss the scope/extent and severity of the problem and needs to be addressed.
(8) How would you characterize the state's approach to the problem-eg. Neo-liberal, social democratic, developmental?

Analysis of the social policy

(1) What are the goals, aims and objectives of the policy? Discuss the stated and implied objectives and what are likely to be the social, economic and political consequence
(2) Who is the social policy aimed at (who benefits directly and indirectly and in what ways,
(3) What theories (functionalism, welfare as citizenship, social administration, and structuralism) and policy approaches (residual, institutional and normative) underpin the policy that you are analyzing or that you are formulating?
(4) Indicate what values and principles these theories present. Discuss the appropriateness of the theories and approach taken by the policy. Clearly indicate how the policy choices are or were made about what social benefits or social benefits are allocated to whom, and how such provisions will be delivered and financed?
(5) Are there any groups, people who will be negatively affected as a result of the policy? Are the overall effects less harmful than the problem/need the policy is designed to resolve?
(6) What social provision does the policy make?
(7) Does the policy establish a minimum standard or norms? Does it establish a benefit schedule? Is the population /category of people to receive the benefit clearly identified and are the criteria for receiving it explicit and unambiguous?

Proposing recommendations

Make any other recommendation that you have not already raised in preceding sections to planners, service providers, affected people and society at large on how the problem or need can be addressed in a way that would result in effective and equitable out-comes.

For the purpose of this study, all the above aspects were explored with the exception of Section 4 of the first aspect and the theories in Section 3 of the second dimension. A content analysis approach was used, which has been defined by Babbie and Mouton (2009:383) as the study of recorded human communications, such as "books, magazines, poems, newspapers, songs, paintings, speeches, letters, laws and constitution, as well as any components or collection therefore".

The findings were presented by extracting emerging themes from the analysis. The study was then concluded by using the aspect of Taylor's frameworks that proposes strategic options for reform as recommendations, which include legislative and policy and institutional and financial recommendations (Taylor, 2008 and 2010).

3.3 Ethical Considerations

Ethical considerations are most common when there is the involvement of participants in the research. These considerations may include protection from harm, informed consent, deception of participants, right to privacy, access to findings and honesty with professional colleagues (Leedy and Ormond, 2010). Since this study does not include direct human participation, the latter ethical issue of honesty with professional colleagues is most relevant. According to Leedy and Ormrod (2010:103), "researchers must report their findings in a complete and honest fashion, without misrepresenting what they have done or intentionally misleading others about the nature of their findings". To the best knowledge of the researcher, these findings have been presented as such.

3.4 Reflexivity

According to Blanche et al., (2006: 482), reflexivity refers to "explicit recognition and examination of the researcher's role in the research process including the assumptions with which they operate, their identifications and dis-identifications and their possible influence on the research process". This suggests that the researcher needs to be aware of her own preconceived notions and supposition. Being from Botswana, this study may have been shaded by the researcher's empathy for OVC, as witnessed by her familiarity with life and circumstances in Botswana.

3.5 Limitations to the Study

The study was limited by five factors. Firstly, the Taylor conceptual frameworks on social protection for Africa (Taylor, 2008) and social policy formulation and analysis (Taylor, 2010)

are quite extensive. Due to the limited space and time, it was not possible to explore all the social assistance provisions, including other possible inadequacies in the social policy responses for OVC in Botswana. Secondly, the study has not engaged with primary sources due to limited time and lack of resources, notably a larger budget. As a result, some unclear results and/or missing facts could not be clarified or substantiated with relevant stakeholders. Thirdly, there are limited academic studies done on social protection provision for OVC and most of the studies that have been done have not been evaluated or analyzed, making it difficult to obtain extensive and current information. Fourthly, at the time of writing up the study results, the national population census, which is conducted every 10 years, had just been completed and most of the preliminary results had not been officially released. Therefore the study has relied on population projections and the most recent data from national surveys. Fifthly, gaining access to government documents – particularly annual reports, the draft OVC policy, and the Social Development Framework – was a major challenge, further constrained by limited time in pursing the research.

CHAPTER FOUR
ANALYSIS OF SOCIAL POLICY RESPONSES FOR OVC IN BOTSWANA

4.0 Introduction

This chapter focuses on the analysis of the social policy responses for OVC in Botswana. The focus is on the objectives of social policies and legislation in relation to social protection for OVC. These policies and pieces of legislation include; the Constitution, the Children's Act of 2009, the National Guidelines on the Care of OVC, and the Botswana National Plan of Action for OVC of 2010-2016 and HIV and AIDS social protection measures stated in Section 1.9 of chapter 1. There is an assumption that, with the existence of social protection measures provided by government, these will be available, accessible and adequate as defined in Section 1.9 of chapter 1. Therefore the HIV and AIDS social protection measures for OVC – namely the prevention of mother-to-child transmission, antiretroviral therapy, community home-based care, and orphan food baskets – are examined.

4.1 Legal and Policy Framework for OVC

4.1.1 Constitution of Botswana

Section 2 of the Constitution of Botswana affords citizens equal protection of their fundamental rights and freedoms (Botswana Government, 1966). Despite this, socio-economic rights, such as social protection, are not recognized in the Constitution as human rights. According to Marshall in Mishra (1977) human equality is associated with the notion of full membership in a community or society. The full membership is explained as dependent upon a possession of three citizen rights: civil, political and social (Mishra, 1977). These rights are recognized in the United Nations Convention on the Rights of the Child (UNOHCHR, 2006) and the African Charter on the Rights and Welfare of the Child (OAU, 1999), both of which Botswana is party to. Piron (2004) and Taylor (2008) stress that social protection needs to be grounded in the human rights-based approach. Thus, the human rights approach obligates government to ensure an adequate standard of living with equal access and opportunity to social protection particular for the vulnerable and marginalized (Taylor, 2008). In addition, social protection has to be guaranteed as a right and entitlement (Piron, 2004). The absence of social protection as a right in the Constitution, thus suggests the lack of a

conducive environment for provision of social protection for OVC, and indeed, disadvantaged groups, such as the *Basarwa* [1](see below).

In 2002, the government made a decision to terminate the provision of basic services to all *Basarwa* in the Central Kgalagadi Game Reserve (CKGR) as part of the relocation strategy (Ditshwanelo, 2006).The *Basarwa* then challenged the government's decision on the termination of essential services. In 2004, the Botswana High Court ruled in favor of the government against *Basarwa*, stressing that the termination of social provisions in 2002 by government in the CKGR was neither unlawful nor unconstitutional (ACHPR and IWGEA, 2008). This suggests that the court had declared that the government had no constitutional and legal obligation to provide social protection stipulated in the destitute and orphan care policy guidelines to those that qualify. The social assistance provisions by government that were meant for OVC, included food basket, meager cash transfer for toiletries, mobile clinics and transport for school children. The court's decision was guided by the constitutional and legislative provisions which fell short of guaranteeing entitlement to social protection for those who meet the criteria.

4.1.2 Children's Act of 2009

The Children's Act of 2009 which is based on the review of the first Children's Act of 1981 (Botswana Government, 1981), recognizes OVC in Section 42 (Botswana Government, 2009). Children's rights to social policy provisions are recognized in various other sections. There is, for example, a child's right to shelter (section 16), clothing (17), leisure play and recreation (19), and protection against harmful labour practices (24) and sexual abuse and exploitation (25) (Government of Botswana, 2009:62). Despite these, the Act falls short of overtly defining social protection: but only mentioned in the in two sections, namely the right to health (Section 15) and the right to education (Section 18) (Botswana Government, 2009).

The right to education as per the Education Act is not compulsory but free for primary schooling only (UNGA, 2006). After 20 years of free education, in 2005 the government reversed its rights-based education policy and reinstated school fees on cost-sharing bases for junior and secondary school (UNGA, 2008). The cost-sharing policy has had its shortcomings. Education International (2009:1) argues that "since 2007 more than 1331 students were locked out of school because their parents cannot pay and there is no adequate program to evaluate those who should be exempt". This locking out is despite government promising not to send any children home for failure to pay fees. This clearly shows that both

[1] Basarwa refers to the San people of Southern Africa who are known to be nomadic hunters and gatherers (Ditshwanelo, 2006).

the Children's Act and Education Act fail to enhance access to education for OVC. The availability of free primary education is in line with the normative approach. However, the secondary school education is made inadequate by the residual model of promoting the principle of efficiency through cost-sharing policy that has shown to limit access to education.

Despite the presence of malnourished, stunted and wasted children (Botswana Government and UNDP, 2010), the Children's Act does not explicitly provide for the right to food and nutrition. Section10 and 15 however can be assumed to be applicable. Section 15 is the right to health and Section10 stipulates that "no person shall take any action or make any decision the effect of which will deprive a child of survival and development" (Botswana Government, 2009:61). According MLG (2008a) most OVC do not have access to more than one meal a day. The limited access to food means that the rights-based approach is not applied to ensure that all children are guaranteed adequate provision. Food and nutrition are paramount to the physical and mental growth of children and therefore need to be adequately provided in order to improve their learning.

4.1.3 National Guidelines on the Care of OVC of 2008

The OVC guidelines seeks to assist organizations and various stakeholders in developing and implementing effective and sustainable program responses to address the needs of orphans and vulnerable children (MLG, 2008b). The aim of building capacity of other institutions to meet the needs of OVC suggests that, responsibility for provisions limits the role of government which resonates within the residual approach that only sees government coming in when other institutions have failed. Social protection is not explicitly pronounced as an important feature of the OVC guidelines. The emphasis is on strengthening the capacity of the community in social provision for OVC. In relation to social protection, the guidelines stipulate that OVC should have access to education, basic health care, food security and nutrition (MLG, 2008b). The guideline provisions are related to social assistance, but fail to act as guiding framework that establishes clear criteria for social protection provision for OVC. Therefore social assistance provision for both orphans and vulnerable children remains fragmented and uncoordinated. For example, there is an orphan care program and vulnerable children are catered for separately under the destitute policy. This results in fragmentation of provision for OVC as a result of not having an integrated OVC policy to guide provision.

4.1.4 Botswana National Plan of Action for OVC of 2010-2016

The NPA in Botswana emphasizes capacity building of the family and community to provide social protection, coordination and building of strategic partnerships, advocacy and monitoring and evaluation (MLG, 2010). However, the NPA points out that there is need for the provision of child-sensitive social protection provision to OVC (MLG, 2010). According to Sabates-Wheeler and Pelham (2006), NPAs for OVC have been adopted by many countries and are aimed at addressing HIV and AIDS. In addition, the NPAs are meant to respond "comprehensively to issues of OVC and to build upon areas which are insufficiently addressed by current OVC-related services" (Sabates-Wheeler and Pelham, 2006:5). In the NPA the social protection measures are stated as food, health care, and education (MLG, 2010). Similar to the Children's Act of 2009, the NPA focuses on a family-centered model. This implies that the responsibility is not on the government but on the family and community that is currently unable to meet the needs of OVC. This limited government involvement to make social protection available for OVC, shows how the residual approach is more prominent but known to be inadequate in meeting needs (Patel, 2005).

4.2 HIV and AIDS Social Protection Measures for OVC

The national HIV and AIDS response in Botswana is aimed at preventing children that are at risk of contracting the HIV virus from getting infected, and to reduce the impact on those who are already infected and affected. To address the HIV and AIDS risks and vulnerability the government provides in-kind social assistance mainly PMTCT, ART, CHBC and orphan food baskets for the benefit of OVC. This section provides an analysis of the availability, accessibility and adequacy of these social assistance provisions.

4.2.1 Prevention of Mother-to-Child Transmission

Availability

PMTCT was first piloted in 1999 before countrywide roll-out in 2002. The HIV and AIDS Treatment guidelines guide PMTCT provision (MOH, 2008). The PMTCT was a direct response to the increasing transmission of HIV virus from pregnant women to their unborn children. The objective of the PMTCT is to prevent the already HIV infected mother from passing the virus onto her child/ children during pregnancy, labor, delivery and breastfeeding. The PMTCT provisions include testing of children at six weeks, free access to antenatal care, pre-HIV testing education of individuals, couples and families, pre-test counseling for those who refuse to test and post-test counseling and psycho-social support to pregnant women and their partners and families following the results, with free infant formula for babies born from

HIV positive mothers (MOH, 2008). The government also introduced routine testing with an opt-out option in all government health facilities in the country. The opt-out policy means that everyone that visits a health facility is offered an HIV test with an option to refuse. Evidence from the NAC report of 2010 noted that there are still pregnant women who decline to test (NACA, 2010). Awareness level of PMTCT is still very limited. The BAIS III of 2008 revealed that only 49.8% of the people aged 10 to 64 are aware of the availability of the PMTCT provision (CSO and NACA, 2009), meaning that more than half of those in that age group are unaware of the service. This lack of knowledge about the availability of PMTCT affects mostly people in rural and remote areas (CSO and NACA, 2009), and could be as a result of provision being limited to 24 health districts and therefore unavailable in rural and remote settlements.

Accessibility

Despite the availability of PMTCT and the fact that Botswana is one of the countries that has moved closer to achieving universal access to PMTCT (UNAIDS, 2010), there are still barriers that remain. The MOH is responsible for both administration and implementation through district health teams. Eligibility criteria for PMTCT are based on the requirements established in the *MASA*- Botswana HIV and AIDS Treatment Guidelines (MOH, 2008). PMTCT is universally offered for free and to all HIV positive pregnant women who are citizens of Botswana and wives of Batswana men (MOH, 2008). According to UNAIDS (2010), 5% of HIV+ women in 2009 did not receive PMTCT. Since PMTCT is provided in district clinics that have antenatal care, pregnant women in remote and rural settlements have difficulty accessing the service due to lack of transport (BOTUSA, 2007). The mobile clinics and health posts that operate mostly in rural and remote settlements do not have antenatal care services. Although government has provision for transport, there is a shortage of vehicles and staff to transport those in need, especially in rural and remote areas (BOTUSA, 2007). The fear of being stigmatized stops lactating mothers from collecting infant formula from the clinic and pregnant women from getting tested for HIV (Kebaabetswe, 2007). The negative attitudes of health workers towards HIV positive patients also obstruct access to PMTCT (Kebaabetswe, 2007).

Adequacy

Adequate provision is still a challenge despite the fact that an increasing number of HIV positive pregnant women are receiving PMTCT. Although the PMTCT is provided to HIV positive women, children benefit indirectly from it. All the HIV negative women are retested

after 36 weeks of pregnancy or at any time when they think that they have been exposed to the risk of contracting the HIV virus (MOH, 2008). PMTCT still faces a number of challenges: some pregnant women are not offered routine testing when they visit health facilities (MOH, 2011c). Young girls who have reached the reproductive age of 15 and are younger than 18 are often not tested by health providers who fear the legal implications as the legal age of consent for testing is 21 years (MOH, 2011c). Furthermore, there are limited skilled antenatal care attendants for women in poor areas (UNICEF, 2011). The inadequate provision of PMTCT means that unborn children are vulnerable to contracting HIV, which can lead to poor health.

4.2.2 Antiretroviral Therapy

Availability

In 2002, Botswana became the first country in Africa to provide ART (MOH, 2008) and HIV pediatric services (BIPAI, 2010). The ARV treatment provision known as *MASA* (meaning new dawn) was introduced to preserve lives amidst the escalating number of HIV and AIDS-related deaths (MOH, 2008). The ART provision to children is aimed at reducing the number of deaths amongst HIV positive children (MOH, 2008). The provision of the AIDS treatment is guided by the HIV and AIDS Treatment Guidelines (MOH, 2008). Children eligible for AIDS treatment are provided with ARV drugs, education on care and treatment for caregivers of an HIV-infected child, infant formula, infant feeding information and counseling, immunization vaccination, and psychological support (MOH, 2008). Similar to the PMTCT, awareness of ART is lower at 48.8% of the people aged 10 to 64 (CSO and NACA, 2009). ARV provision is currently available for children at 33 treatment sites in 24 districts. These sites include public referral hospitals and clinics. Hence, ART is provided throughout the country. There is a lack of information on how many children were registered to receive ART: only the number currently receiving ART is available, and this stood at 8490 children in 2009, with an estimated 9400 to11000 needing treatment (UNICEF, 2010).

Accessibility

ARV provision is still not reaching all vulnerable children that need it, which includes orphans. The MOH takes the lead in both administration and provision at district level. ART is provided for free to all children who are citizens of Botswana and who meet the eligibility criteria (MOH, 2008). Children who are eligible to receive treatment are those: who are infected with HIV virus and less than one year of age irrespective of CD4 count; and those who have advanced or severe immune suppression or an AIDS-defining illness (MOH, 2008).

In addition, children who are infected with HIV and are over the age of 14 years are considered adults and therefore are eligible to ARV provision only when their CD4 count is ≤ 250 cells or with defining illness (WHO clinical stage 3 or 4) (MOH, 2008). Furthermore, priority patient populations are pediatric and adolescent patients and those with HIV/TB co-infection.

Children between the ages of 15 and 17 and infected with HIV virus are only eligible for AIDS treatment if their CD4 count is ≤250. ART is provided in all the public hospitals and some of the major clinics. Mobile clinics are also suppose to visit remote areas every once a month (BOTUSA, 2007). Some of the barriers to accessing ART by HIV positive children have to do with the health care providers not providing routine or rapid HIV testing to children because of the legal age of consent for testing of 21 years (MOH, 2011c). The lack of skills to provide counseling to children by health care providers also limits access to treatment (MOH, 2011c). In addition, caregivers sometimes do not keep regular clinic appointments or do not take children to the clinic when they are sick (MLG, 2008a). Since provision in remote areas is once a month, the lack of transport and staff makes it unreliable (BOTUSA, 2007).

Adequacy

The estimated annual cost of AIDS treatment for a child ranges from US$284 to US$ 3150. Since children over the age of 14 are considered adults, their treatment cost ranges from US$244 to US$1096 per annum (Botswana Government and UNAIDS, 2010). According to UNICEF (2010), the number of children aged between 0-14 living with HIV was estimated to be between 16 000 and 20 000 with 8470 receiving assistance. This leaves an estimated 7530-11 530 who qualify for treatment but who are excluded from government provision. ART for children is mostly provided by government but some children are catered for through public-private partnerships (BIPAI, 2010). The Botswana government in collaboration with the BIPAI, provides AIDS treatment to children younger than 14 years of age (Botswana government and UNAIDS, 2010). But this is still not adequate due to lack of funding, and money to transport children to the Baylor clinic (BIPAI, 2010). The lack of treatment for children with HIV might cause unnecessary deaths.

4.2.3 Community Home-Based Care Food Basket

Availability

CHBC was first initiated in 1995 due to the increasing patients with HIV and AIDS- related illnesses and the inability of hospitals to accommodate all the chronically/terminally ill patients (MOH, 1996). The aim of food provision to home-based care patients with AIDS is to boost their immune system so that they are able to fight the disease. CHBC later shifted focus to all bedridden patients, irrespective of their illness. Although slightly higher than the PMTCT and the ART, the level of awareness of CHBC is still very low. The types of assistance provided to beneficiaries of home-based care are food basket, transport, repatriation and rehabilitation. The social assistance provision seeks to provide quality, care, counseling, and psycho-social and spiritual support to terminally ill patients. A patient on oral feeding, which is the provision of nutritional foods using a tube, qualifies for a food basket worth not more than US$200. Whereas a patient that is not on oral tube feeding receives a food basket with a value of up to US$80 (MLG, 2011).

The available data only provides the level of awareness of the overall program and not specifically of the food basket. Currently 53.2% of the people aged between 10 and 64 years are aware of the CHBC provision (CSO and NACA, 2009). The low level of awareness of CHBC suggests that the existence of the food basket might not be well known. Only those who have registered are beneficiaries of the food basket, which is provided at the health district. The NAC report does not disaggregate its data by age, making it difficult to establish the number of registered children for the food basket and those that have AIDS for the fear of stigma. By end of December 2010 there were 1632 registered for the CHBC food basket, with only 1626 receiving food basket, thus leaving out 6 people in need.

Accessibility

The administration of the CHBC, which includes the food basket, is the responsibility of MOH. The food basket is collected and distributed through district health teams, to the homes of patients by volunteer caregivers, who are mostly retired nurses employed by the government (Kang'ethe, 2009). There are still challenges of access for people that are eligible to receive food baskets. All citizens of Botswana who have been certified as bedridden by a government-registered medical care practitioner are eligible to receive a food basket. The monthly food basket has to be prescribed by a dietician or medical doctor (MOH, 2011a). There are mainly two types of patients: those who are fed orally through a tube and those that are not. CHBC beneficiaries are mainly from rural areas (RHVP, 2011). Although

the CHBC is meant for any chronically ill patients, most participants suffer from AIDS. Despite provision to CHBC being open to any chronically bedridden patients, stigma and discrimination still prevent people from seeking assistance. Since the CHBC is often associated with HIV and AIDS, some potential beneficiaries do not seek for help with the fear of being stigmatized and discriminated against (Odek and Oloo, 2007). In addition, assessment results from social workers take a long time to be finalized, thereby delaying the registration of potential beneficiaries (Kang'ethe, 2009). Another constraint relates to shortage of staff to assess potential recipients and the shortage of caregivers who distribute the food to patients (Shaibu, 2006). Furthermore, the caregivers often lack money for transport to distribute the food to CHBC patients (Kang'ethe, 2009).

According to the (CSO and NACA, 2009), in 2008 there were 1124 bedridden children aged 14 years and under. The NAC report of 2010 indicated that by end of December 2008 there were 3671 registered beneficiaries for the CHBC food basket program. However, the number of those that were registered and benefited from the food basket was 3657. Due to lack of disaggregated data, it was difficult to establish how many children actually received their food basket.

Adequacy

The CHBC government funding is included in the AIDS treatment and care budget. Therefore, it has also been affected by the budget cuts for 2011/2012. Since the number of registered beneficiaries of CHBC is not disaggregated by age, it is difficult to establish the number of children who are covered and those who do not receive food assistance. The lack of information on children on the CHBC, especially with regard to food basket provision, means that there is limited analysis on the adequacy of the CHBC with regard to food basket provided to vulnerable children. Since the study did not include interviews and limited literature on children in the CHBC, this study was not able to attain information on the adequacy of the CHBC with regards to children. General information can however shed light on some of the issues. According to Kang'ethe (2009), those that receive food still find the baskets inadequate to meet their needs as they share the basket's contents with members of their households.

4.2.4 Orphan Food Basket

Availability

Prior to the STPA, food provision for orphans was catered for under the National Policy on Destitute Persons (1981). The food basket includes a meager cash transfer to cater for toiletries. Despite the existence of food provision before the HIV and AIDS crises, the level of awareness of the OVC program, which includes the food basket, is still very low. There is no specific data on level of awareness on the food basket. Only 55.7% of the populations between the ages of 10 and 64 are aware of the program (CSO and NACA, 2009). This means that the knowledge on the food basket is also affected. According to CSO and NACA (2009), the rural population as compared to the urban lacks knowledge on the availability of the orphan care program. The food provision is across districts and towns but mostly in rural areas (RHVP, 2011). Hence, there is nationwide provision for orphan food basket to those who have been registered. As of June 2011, 41 801 orphans were registered (NACA, 2011). Only 41 408 received their food basket, suggesting that 393 (approximately 1%) of the orphans who are registered do not receive their food provision.

Accessibility

Orphans are still faced with problems of accessing food provided by government. The food basket for orphans is administered by the MLG and implemented at district level by social workers under the Department of Social and Community Development (SNCD) (MLG, 2008a). For an orphan to qualify for a food basket, they must be citizens of Botswana and under the age of 18 years (MLG, 2010). In addition, they must have lost a single or both parents (customary or civil marriage), whether biological or adoptive. In addition, they must be identified either by a teacher, social worker, relatives, community leaders, or members of the community. The social workers then assess the child's situation to determine eligibility for registration. More orphans are found in rural areas than in urban areas (RHVP, 2011).

Orphans receive their food basket through local markets or, where these do not exist such as in remote areas, from social workers (MLG, 2008a). Children still experience challenges in accessing their food basket. The government budget allocation is not able to meet the high orphan demand and gets exhausted before the financial year ends (Tsheko, 2007). This often results in social workers not distributing the food basket to some of the orphans (Feranil et al., 2010). The 2011/2012 allocation for OVC is P260 million (Kayawe, 2011) or US$43 million. This is a significant reduction from the 2008/9 government expenditure of P537, 22,113 million (US$90) million (Botswana Government and UNAIDS, 2010). The shortage of staff

and transport also makes it difficult for orphans to be assessed, registered or given food, especially those in rural areas (Maudeni, 2009). In some cases, caregivers do not register orphans due to the stigma attached to the provision, which implies that they are poor or that their family is affected with HIV and AIDS (Tsheko, 2007).

Adequacy

There are still obstacles to sufficient provision of orphan food basket. The food transfer is aimed at improving the nutritional status of orphans. An orphan is given a monthly food basket containing items such as maize meal, rice, meat and vegetables, and including toiletries (Tsheko, 2007). The food is not based on the nutritional needs of beneficiaries. The value of the food basket ranges from P450-700 or US$75-117(RHVP, 2011). The 2008 BAIS III reveals that there were 117 567 orphans in the country (CSO and NACA, 2009). With only 41 801 registered for the food basket, this suggests that the remaining 75 766 (about 64%) of orphans are not covered.

Even using the international definition, there is still a shortfall in coverage. The 2010 UNAIDS Global report stated that in 2009 there were approximately 93 000 AIDS orphans in Botswana (UNAIDS, 2010). This means that close to 45% of the AIDS orphans are not covered. According to MLG (2008a) the government has the highest coverage for food provisions other than non-governmental, faith based and community organizations. This means that there are orphans who might not be receiving any food assistance. Supermarkets awarded tenders to supply food would "sometimes not provide fresh perishables" (MLG, 2008a) or would provide food baskets with some items missing (Tsheko, 2007). In addition, caregivers feed their own children with the food that is meant for orphans, or sell the food to raise cash (Tsheko, 2007). This means that even orphans who qualify for provision either they do not receive it or receive inadequate provision. This lack of food results in inadequate nutrition, which can in turn lead to malnutrition impacting on the orphan's health and inability to properly learn at school.

CHAPTER FIVE
FINDINGS, CONCLUSION AND STRATEGIC OPTIONS FOR REFORM

5.0 Introduction

This chapter discusses the findings of the analysis, conclusion and suggests strategic options for reform as recommendations. The focus of this study was to explore the social policy responses for OVC provided by government of Botswana. The aim was to determine whether the social policy measures are meeting the needs of OVC. It analysed social protection objectives in the provisions of legislation and policies affecting OVC. The HIV and AIDS related social assistance measures for OVC which included the PMTCT, ART, CHBC and orphan food baskets, were also analysed in relation to their availability, accessibility and adequacy. The analysis in Chapter four has shown that the social policy measures are not meeting the needs of OVC due to the inadequacies revealed in the social protection system. The identified gaps are: inadequate policy and legal framework, fragmentation of social assistance provisions, minimum eligibility criteria, shortage of human resource, insufficient funding, lack of awareness, and the presence of stigma and discrimination. The findings of the analyses will be discussed using the Taylor Frameworks (2008 and 2010). Where appropriate, the theories on social policy provision will also be used as well as insights from available literature on the issues.

5.1 Findings

5.1.1 Inadequate Legal and Policy Framework

The inadequate legal and policy framework relates to the Constitution, the Children's Act of 2009, the Education Act and the legal age of consent for HIV testing. The lack of constitutional and legislative provision for the right to social protection has resulted in OVC not being able to seek redress when government withdrew all social provisions for *Basarwa* who resided in the CKGR (ACHPR and IWGEA, 2008). The High Court ruled that the government did not have any constitutional nor legislative obligation to provide such services (ACHPR and IWGEA, 2008). Since the Constitution has not enshrined socio-economic rights, the right to social protection is not recognised in the Constitution. This has been further exacerbated by the lack of strong legislation. Although, the Children's Act recognises the right to health and education for children, the responsibility is more on the parents and

guardians. The government assists OVC who lack access to health and education by exempting them from paying fees. However, the assistance is not legally guaranteed for those who qualify. Therefore, the beneficiaries cannot claim it as a right and those who do not get assistance remain excluded, as it has been the case when social workers do not have enough food baskets to distribute.

Mishra (1977) argued that residual-neoliberal social provision has limited statutory provision. In Botswana, "social security provisions are presently implemented through policy guidelines rather than being embedded in the proper rights-based approach" (Ntseane and Solo, 2007). This is the case with the HIV and AIDS social protection provisions for OVC. The ART, PMTCT and CHBC and orphan food baskets are all in-kind provisions that are not legislated. Piron (2004) and Taylor (2008) stressed that social protection is a matter of right and entitlement. Therefore social protection is not charity.

Botswana has made significant gains in access to education. The Children's Act and Education Act recognises the right to free primary education, but are insufficient in recognising free and compulsory basic education. The cost-sharing policy of government has impacted on the school attendance of children (Education International, 2009). Hence, there are vulnerable children that still lack access to education because they are unable to pay school fees. Despite the government's policy of exempting OVC from paying school fees, some children are still made to pay. Inadequate legislation means that the poorest children are more affected. Some of the OVC also drop-out, either because they are unable to travel the long distance to get to school or because there is a language barrier (MLG, 2008a). In addition, the current legal age of consent for HIV testing is 21 years. Children that request for HIV testing sometimes do not receive it since health care providers are often reluctant to provide the test because of age of consent (MOH, 2011c). This has implications on the children who are between the ages of 15 and 18 as the lack of testing means that those that are HIV positive are not able to access early treatment, which could save their lives and, for those who are pregnant, the lives of their unborn children.

5.1.2 Fragmentation of Social Protection Provisions

Social protection provision for OVC is fragmented. Despite the MLG being the key Ministry responsible for the OVC, their policies for provision are not harmonised. The vulnerable children are catered for under the destitute policy and orphans by the orphan care program. Currently there is no policy document to guide social provision for OVC. The 2008 guidelines

that should guide provision for OVC focus on community capacity building. These guidelines need to be reviewed so that their focus is on procedures for provision for OVC. The draft OVC policy that is currently being developed (Feranil et al., 2010) has not been accessible from government, hence its contents are not known for the purpose of this study.

5.1.3 Minimum Eligibility Criteria

The minimum eligibility criteria set by government excludes OVC from accessing social protection provision. In particular, children between the ages of 15 and 18 years who are infected with HIV virus with a CD4 count that is more than $\leq$250 are denied early ARV treatment. This has impacted on the children's access to ARV treatment as they "fall through the cracks and lost to consistent follow up" once they graduate from the PMTCT program (NACA, 2009:26). Taylor (2008) suggests that an agreed socially acceptable minimum is often a challenge, especially during economic difficulties. In addition, universal social protection provision outweighs the cost of mean testing. The minimum criterion set by government falls short of the recommended WHO threshold of CD4 count of $\leq$ 350. This suggests that there could be a significant increase in the number of children accessing treatment. Also, as children between 15 and 18 years are considered adults when it comes to AIDS treatment, this could be contributing to the high number of deaths amongst adults caused by HIV and AIDS. Inadequate AIDS treatment for children could exacerbate the already low life expectancy of 55.5, which costs the country a future human resource that could contribute to future economic growth.

5.1.4 Shortage of Human Resource

The shortage of human resource and the lack of skills are major bottlenecks, not only for the OVC social protection provision, but for the overall HIV and AIDS response. Both the MOH and MLG are faced with shortage of service providers. The number of health care and social workers, who are key providers for OVC, are inadequate to meet the current needs. According to Botswana Government and UNDP (2010) the lack of health personnel and adequate skills has put a strain on the health system to deliver AIDS treatment. The reasons for inadequate health providers are brain drain and unfavourable working conditions (WHO, 2009). In addition, the health care providers lack skills in paediatric care and providing disclosure counselling to children (MOH, 2011c). The short supply of social workers makes it difficult to assess, register, provide food baskets and monitor OVC (Mandeni, 2009). Ntseane and Solo (2007) suggest that on average, one social worker handles 629 cases, covering five villages. This lack of human resource has resulted in poor social provision to OVC.

5.1.5 Insufficient Funding

There is still insufficient funding for OVC provision relative to the current demand. Due to the limited budget allocation, some social workers often have to decide which OVC will receive food baskets and which will not (Feranil et al., 2010). In addition, the funds for OVC also run out before the financial year ends (Tsheko, 2007). The residual-neo-liberal social policy provision has low government financing and is more concerned with the cost of provision than being equitable (Williams, 1989). Taylor (2008) argues that the financing of social protection is more of a policy decision than the lack of resources. In the latest report, President Ian Khama noted that funding for AIDS programs had become too costly for the government (Kayawe, 2011). The result of this can be observed in the reduction of the budget allocation for this financial year. Currently, the 2011/2012 government allocation of P981 million/US$1.650 million (Kayawe, 2011), is a reduction from P1, 549,573,817/US$258 million) for the period of 2008/2009 (for the 2010 UNGASS reporting period; Botswana Government and UNAIDS, 2010).

Another constraint on funding is the classification of Botswana as an upper-middle income country. The result of which has been donors pulling out to shift their funding focus to poorer countries (Botswana Government and UNAIDS, 2010). This means that the government remains a critical financier since the NGO also lack resources as they also depend on both the government and the limited donor funding. For the overall HIV and AIDS funding for 2008/9, the estimated government spending was 66%, with 32% coming from development partners (USAID, ACHAP and UN agencies) and the remaining 2% from local contributors, notably the private sector, non-for profit institutions and organisations, including private individuals (Botswana Government and UNAIDS, 2010). Despite government being the key player in financing OVC provision, there has been significant reduction in government spending. For the period of 2008/2009, the government committed 34.6% of P2,358,720,853/US$ 39 million for OVC in the national response on HIV and AIDS. This is the second largest share after the care and treatment program, which is 56% of the total government expenditure in the fight against the pandemic. However, for the financial year of 2008/2009 the OVC spending was P537, 222,113 million /US$90 million (NACA and UNAIDS, 2010).The financial year allocation for OVC for 2011/2012 has been significantly reduced to P260 million / US$43 million (Kayawe, 2011). This is a major decline in funding. Funding for AIDS treatment, which also includes children, has been reduced to P185 million/ US$31million from the combination of care and treatment that was P869, 687, 872/US$145 million for the period of

2008/2009. The insufficient funding also has an impact on shortage of staff, transport and office space, making it difficult to reach OVC that are in remote areas.

5.1.6 Lack of Awareness

Another problem for social protection provision for OVC is the lack of awareness of such provision. Spicker (1995) argues that selective provisions do not reach people in need because of ignorance about the services. Despite social provisions for OVC being provided as far back as 1999, the latest evidence from BAIS III has revealed that there is still ignorance regarding the existence of HIV and AIDS social protection provisions, in particular the PMTCT, ART, CHBC and orphan provisions. According to Sabates-Wheeler and Devereux (2004) and Taylor (2008), even when social protection provisions are in place, access is still hampered by the lack of information. Both the PMTCT and ART have just under half of the people not aware of the provisions. Only 48.8% of people know about the availability of ART, with 49.8 % aware of the availability of the PMTCT (CSO and NACA, 2009). The CHBC and the orphan care provisions are slightly above half but also still very low. The level of awareness of the CHBC is 53.2% with the orphan care provision being the highest but still way below at 55.7% (CSO and NACA, 2009). This could be as a result of the provisions being too distant from reach by beneficiaries. In addition, deserving children are not accessing social protection provisions due to households with vulnerable children not aware of such benefits (Tsheko, (2007). The rural communities lack information more than urban areas (CSO and NACA, 2009). This suggests that there is inadequate information on the availability of the social protection provisions for OVC, as such not all OVC are able to be reached.

5.1.7 Stigma and Discrimination

Stigma and discrimination is another major barrier to OVC provision. George and Wilding (1994) pointed out that selective provision has a disadvantage of being socially divisive. In particular, selective social provisions fail to reach people in need due to stigma and discrimination (Spicker, 1995). Since the advent of HIV and AIDS in Botswana, stigma and discrimination against people living with HIV became common because of its association with sex workers and sexual promiscuity (Odek and Oloo, 2007). Therefore, it is not uncommon for people to refuse to participate in social provisions that are related to HIV and AIDS.

Taylor (2008) argued that the function of social protection is to be transformative in order that the barriers that hinder access, such as stigma and discrimination, can be addressed. Stigma

and discrimination has lead to caregivers not registering OVC for fear that they will be stigmatized, as the social assistance provision is seen to be for families affected by HIV and AIDS, which they do not want to be identified with (Tsheko, 2007). Another factor is that pregnant women decline to test for HIV in order to save themselves from being stigmatized if they are found to HIV positive (Kebaabetswe, 2007). However, an HIV test result is important so that an HIV-positive woman can enrol for provision in order to benefit her unborn child. This lack of testing puts the unborn baby at risk of contracting the HIV virus. In addition, HIV positive women that have opted to go with exclusive breastfeeding do not collect their infant formula to avoid being seen at the distribution points (Kebaabetswe, 2007). Despite CHBC being for all chronically ill patients, those who are not HIV positive refuse to be enrolled for the fear or being stigmatized (Shaibu, 2006). The negative attitudes of the service providers also exacerbate the problem of stigma and discrimination and therefore hinder access to social provision by OVC (Kebabetswe, 2007). This implies that social protection is not transformative and therefore inadequate since it excludes OVC from accessing provision due to stigma and discrimination.

5.1.8 Impact of Economic Policy on Social Policy

Botswana has been categorized by the World Bank as an upper middle-income country with a per capita GDP of more than US$13,000 (WB, 2010). This was not the case at independence in 1966, when Botswana was amongst the poorest countries in the world as a result of harsh and prolonged droughts. At that time it had a per capita GDP of US$140 and depended on donors for support (Tlou and Campbell, 2003). According to Mwansa et al., (1998) social provision such as "education and health services were rudimentary and inadequate... and there was no comprehensive housing policy and economic opportunities were very limited" It is argued by Midgley (1995) that economic growth is needed in order to pursue social goals. Consequently, economic policy affected the distribution of resources through social provision. However, the current economic situation makes Botswana a well-off country that should be in the position to sufficiently provide for the needs of its small population. The diamond discovery in 1967 has since injected substantial government revenue, but a mixed approach to development has not adequately met the needs of the population through its social policies. The impressive growth is accompanied by the persistent HIV and AIDS epidemic, poverty, unemployment which has widened the gap between the rich and the poor.

The inequality that has manifested in income disparities has affected the human development of its population. Throupe (2011) suggested that Botswana is one of the most unequal countries in the world. According to the 2010 Human Development Index, Botswana's human development, which combines health, education and income, is 0.633, which equates to a ranking of 98 out of 169 countries in the world (UNDP, 2010). Even the current Minister of the MFDP, Mr O. K. Matambo in his February 2011 budget speech noted that the poverty situation in the country was "not acceptable by any standards" (MFDP, 2011). Oyugi (2008) argues that Botswana changed from an economy based on agriculture which made up 40% of the GDP to a diamond-driven economy. This suggests that people are no longer depended on subsistence farming to meet their basic needs such as food. Therefore, earning an income to put food on the table for children, transport to go to school and visit the clinic, including buying descent clothes has become an important part of people's lives.

It is argued by Mkadawire in Osei-Hwedie (2007:25) that Botswana cannot be considered a developmental state because of "failure to reduce poverty, human deprivation and disempowerment of the poor". Hillbom (2008:192) further asserts that Botswana is characterised by growth without development since the country has a "deplorable growth with diving social indicators". This indicates that the fruits of growth have not significantly improved the living conditions of the poor. The factors that have contributed to slow pace in poverty reduction are failures of the market to provide jobs, lack of skills, and poor health. These challenges have had dire consequences on rural women, the elderly, OVC, and *Basarwa* communities who reside in the most remote areas. *Basarwa* are viewed as the most disadvantaged and known to be at the bottom of the social, economic and political strata of the society (Bojosi, 2009). They have poor nutrition, lack access to education, health care, land and voice to influence the policies that affect them (UNGA, 2010 and Nthomang, 2004). As such, children that grow up in these communities have limited opportunities perpetuating generations of the poor.

5.2 Conclusion

The study has explored the social policy responses for OVC by government of Botswana. It is clear that Botswana does not have a comprehensive social protection policy for OVC. The analysis of the policy, legislation, and HIV and AIDS social protection measures has shown the inadequacies in the social protection system for OVC. Firstly, the identified reasons for limited social protection provision pointed to the inadequate legal and policy framework, fragmentation of social protection provisions, inadequate minimum eligibility criteria,

shortage of human resource, insufficient funding, lack of awareness, and stigma and discrimination. The economic policy has also had devastating impact on the poor, especially OVC. Secondly, the gaps that exist emanate from an approach that has not significantly changed since independence. Although the social policy provision for Botswana has elements of the intuitional and normative approaches, the residual-neoliberal approach appears to be dominant.

The inadequate legal framework for OVC has shown its limitations by not guaranteeing the right to social protection, especially in protecting the marginalised *Basarwa*. The rights-based approach, which is linked to the transformative function of social protection aimed at enabling access to the socially vulnerable and marginalised groups such as *Basarwa* OVC, has been shown to be weak due to the lack of statutory provision. This is however not surprising as most of Botswana's social assistance provisions are guided by guidelines that lack legal backing. For that reason, some of the OVC remain excluded from social protection. The minimum eligibility criteria also exclude some of the OVC in need of social protection, especially the AIDS treatment provision. Although government has to decide on the socially acceptable minimum eligibility criteria within the available resources, it should be more inclusive, especially for children who are the future human resource of the country. The AIDS treatment is meant to save lives, and with a country with such high mortality rate and low life expectancy as a result of HIV and AIDS, there is need to curb unnecessary deaths among children. When children fall sick due to lack of treatment, this not only impacts on their health but also on their education as they have to miss school. The cost of AIDS treatment is indeed expensive, but it does not surpass the cost of a human life.

Insufficient funding means that Botswana has to be creative in coming up with mechanisms to raise more money so that the needs of OVC will be met. OVC funding is tied to the overall national HIV and AIDS response, and as such the mobilisation of resources for OVC will have to be done within the AIDS response. Without a cure for HIV and AIDS, declining external donor support and weak resource capacity of NGOs, government is left with no other alternative but to find an internal, long term and sustainable solution for the overall national HIV and AIDS crises, which has negatively impacted on the well-being of children. AIDS treatment is critical in saving children's lives. Therefore, resources for the national HIV and AIDS response will need to be generated domestically so that OVC can have adequate social protection to improve their health and nutrition and be able to have better education that can secure a better future and break intergenerational poverty.

Insufficient government spending is also linked to the shortage of human resource. Social workers and health care providers are pre-requisites for successful social provision to OVC. The government has to come up with strategies that provide lasting solutions to the problem, as the lack of human resource impacts negatively on OVC. OVC are not able to access social protection, either because they have not been assessed or registered, or because they have not been given their provisions. It also follows that some of the people are not aware of the existence of the OVC social provisions. The levels of awareness are significantly low especially that the social protection provisions have been in place close to a decade now. The availing of information and public education to raise awareness, especially in rural and remote areas has to be intensified together with addressing stigma and discrimination which has been persistence since the advent of the HIV and AIDS epidemic.

The lack of a rights-based developmental approach, which is more comprehensive than the residual-neoliberal and institutional-social democratic, highlighted the shortcoming of social protection provision and the socio-economic-demographic status of OVC. Therefore, social protection needs to be grounded in the rights-based developmental approach so that OVC can have adequate health, education, food and nutrition.

5.3 Strategic Options for Reform

The recommendations are based on the findings of the analysis and focus on strategic areas of reform as relating to legislation, policy, institutional and financial arrangements.

5.3.1 Legislative and Policy Recommendations

Recommendation 1

Botswana should incorporate socio-economic rights so that social protection is integrated in the constitution as a human right. In addition, *Basarwa* should also be given special protection in recognition of their disadvantaged status so that past and present social, economic and political exclusion do not lead to the intergenerational poverty of *Basarwa* children.

Recommendation 2

The government needs to review both the Children's Act and Education Act and revert back to providing free basic education, and make it compulsory. This would provide a strong legislative framework that would be based on the rights-based approach and will better serve the needs of OVC.

Recommendation 3

There is a need to harmonize the age of HIV testing. The current legal age of consent is 21 years, while the non-statutory HIV testing guidelines have the age of testing at 15 years. The age of consent for testing could remain at 15 years but needs to be written into law. This will enable more children to know their HIV status, resulting in early access to treatment. In addition, the health service providers will also feel free to offer the service to children without fearing the legal implications for providing such assistance without parental consent.

Recommendation 4

The government needs to expedite the development of the OVC policy. The current guidelines and plans are insufficient, as they are not meant to guide social protection provision for OVC. Within the policy, a comprehensive social protection framework needs to be clearly articulated to guide social protection provision for OVC.

Recommendation 5

The *MASA* HIV and AIDS treatment guidelines need to be amended so that ART is universally provided to all children infected with HIV or have the CD4 count at the recommended minimum international standard. The Children's Act of 2009 stipulates that children have the right to health. Children that are currently infected with HIV, especially those over the age of 14 years, are not eligible for treatment when their CD4 is $\leq$250. With the universal provision of AIDS treatment, deaths among children could be reduced. Children will not have to wait to fall ill before they are able to access treatment, but will have improved health and be able to concentrate at school. The cost of the country's children dying is the loss of a potential human resource that could enhance the development of Botswana.

Another option for increased access to AIDS treatment is to raise the requisite CD4 count to $\leq$350, which would be in line with the WHO recommendation. This would be a significant step in realising the right to health for children. The cost of not providing children with adequate treatment will even be greater, as it will hamper the school progress of those children while they are being treated. The government will also have to bear the cost of children having to repeat school due to illnesses as a result of treating opportunistic infections.

5.3.2 Institutional and Financial Recommendations

Recommendation 6

Social workers and health care providers are critical human resources in social protection provision especially for OVC. Long-term strategies are needed to bridge the human resource gap to be able to address the persistent problem of OVC. The MOH needs to complete and implement the human resource plan for health care workers. Similarly, the MLG could consider developing a human resource plan for social workers.

Recommendation 7

Government could consider raising funds by replicating the Zimbabwean model and establishing a national AIDS trust fund. External donor funding is not a viable option because of its upper middle-income status and the declining global donor funding for HIV and AIDS. Hence, Botswana needs to find an alternative means of raising funds for social protection provisions for OVC. This will require a strategy that mobilizes funds for the overall national HIV and AIDS response. Zimbabwe is regarded as a best practice for setting up a National AIDS Trust Fund that acquires funds from taxing formal workers and their employers (SADC, 2008). Another option could be accepting local donations. This will enable the country to be independent of external support and have more sustainable provisions.

Recommendation 8

A clear strategy for informing the public on the availability of HIV and AIDS social protection provisions needs to be put in place. This will need to be incorporated into the OVC policy with a clear indication of how it is to be implemented, and who will be responsible for such an undertaking. Priority should be given to rural and remote areas since the level of awareness is much lower there than in urban areas.

Recommendation 9

There is a clear need to address stigma and discrimination. The government could consider setting aside resources for public education for social change through a range of approaches to address these. For example, social media can be used. In addition, health care providers can be trained to address their attitudes towards beneficiaries of social protection provisions.

This study has explored the policy measures in place for OVC in Botswana and has deepened the policy understanding of what needs to be addressed to better meet the needs of OVC. Without addressing the above recommendations, the OVC will continue to lack access to

social protection such as health care and education. In particular, children will continue to be vulnerable to being both infected and affected by the HIV and AIDS. This will result in deaths, poor physical and mental growth affecting the survival and development OVC. In addition, intergenerational poverty is likely to persist as most of the OVC are from poor households if the government does not address the needs of OVC.

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